



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2023

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

Re: Reinspection Results
Event ID: IQ7G12

Dear Administrator:

On August 28, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



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Electronically delivered
September 8, 2023

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: June 29, 2023

Dear Administrator:

On August 2, 2023, we notified you a remedy was imposed. On August 15, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 28, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 17, 2023 be discontinued as of August 28, 2023. (42 CFR 488.417 (b))

In our letter of August 2, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 12, 2023. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
August 2, 2023

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

RE: CCN: 245400
Cycle Start Date: June 29, 2023

Dear Administrator:

On August 1, 2023, we informed you that we may impose enforcement remedies.

On July 12, 2023, survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On July 12, 2023, the situation of immediate jeopardy to potential health and safety cited at F686 was removed. However, continued non-compliance remains at the lower scope and severity of D.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 17, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430

through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 17, 2023, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 17, 2023, (42 CFR 488.417 (b)).

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 12, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information,**

you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Wabasso Restorative Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 12, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this

letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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/lrc_idr.cfm

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

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

Feel free to contact me if you have questions.

Wabasso Restorative Care Center

August 2, 2023

Page 7

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 2, 2023

Administrator
Wabasso Restorative Care Center
660 Maple Street
Wabasso, MN 56293

Re: State Nursing Home Licensing Orders
Event ID: IQ7G11

Dear Administrator:

The above facility was surveyed on July 5, 2023 through July 12, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Wabasso Restorative Care Center

August 2, 2023

Page 2

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,



Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/24/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/12/2023
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/5/23,7/6/23, 7/10/23, 7/11/23, and 7/12/23, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. The IJ began on 6/26/23, when wound clinic identified R1's wound had deteriorated to the bone from improper dressing placement and mismanagement of the wound vac. The administrator, and director of nursing (DON) were notified of the IJ on 7/10/23 at 5:45 p.m and removed on 7/12/23. The following complaints were reviewed: H54003321C (MN00094857 and MN00094907) and H54003412C (MN00094867) with a deficiency cited at F686 and F726. The above findings constituted Substandard Quality of Care and an extended survey was conducted on 7/11/23. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2023

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245400	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/12/2023
NAME OF PROVIDER OR SUPPLIER WABASSO RESTORATIVE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 660 MAPLE STREET WABASSO, MN 56293		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page 1	F 000			
F 686 SS=J	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive pressure ulcer assessments and ensure physician ordered wound vac therapy was adequately managed for 2 of 3 residents (R1, R3) who required wound vac therapy. The facility's failures resulted in an immediate jeopardy (IJ) for R1's when their pressure ulcer deteriorated resulting in necrosis, bone exposure and hospitalization. The immediate jeopardy began on 6/26/23, when wound clinic identified R1's wound had deteriorated to the bone from improper dressing placement and mismanagement of the wound vac. The IJ was identified on 7/10/23 and the administrator, assistant administrator, and director of nursing (DON) were notified of the IJ	F 686	F686– Treatment to Prevent/Heal Pressure Injuries 1. R1, R2, R3, and R4 have the potential to a serious adverse outcome. No other residents were identified. 2. All residents with wound vac have the potential to be affected in this area. 3. Facility Wound Vac Policy updated to reflect PCC wound assessment will be completed Weekly on scheduled day placed on MAR and when changes in wound are observed with scheduled dressing change. PCC assessment includes photo of wound, measurements, and wound assessment. If dressing needed between scheduled dressing changes a PCC wound assessment will		8/10/23

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F 686	Continued From page 2 on 7/10/23 at 5:45 p.m. The immediate jeopardy was removed on 7/12/23, but noncompliance remained at the lower scope and severity level of D- isolated with no more than minimal harm that is not immediate jeopardy. Findings include: Stage 4 pressure ulcer as defined by the State Operation Manual, last updated 11/22, is full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Negative Pressure Wound Therapy (NWPT) also known as a wound vac helps to heal wounds by providing a moist environment, promote new tissue formation, and removing excess fluid and infection. Negative pressure wound therapy uses suction, tubing, and wound dressing to remove excess exudate and any infectious material that may be present in the wound. Negative pressure wound therapy, also called "wound vac" or "NPWT," provides an ideal and clean environment to promote wound healing in acute or chronic wounds. Offering significant clinical benefits for large, chronic wounds and acute, complicated wounds, negative pressure wound therapy is used by healthcare teams and wound care specialists to support faster wound healing. The negative pressure or vacuum suction is provided by a pump that is connected to a wound. A foam dressing is placed in the wound and covered with an occlusive dressing. The fluid that is removed is collected in a canister on the pump. A Vulnerable Adult Maltreatment report submitted to the state agency (SA) on 6/27/23 at 9:10 a.m., indicated the facility incorrectly followed wound	F 686	be done prn with changes in wound status. 4. Wound assessments per PCC wound program will be completed at a minimum of a schedule weekly and PRN with any wound changes, care plans to reflect wound vac use and orders updated to check settings & power source every four hours and document on TAR. Wound Vac machines have an alarm for 15 minutes of battery left to alert staff of low charge. Drainage and for signs and symptoms of infections and observation of skin under tubing order will be placed in TAR to be checked and documented every 8 hours. 5. Policy updates completed after discussion with wound vac educator. Wounds vac areas of all residents affected will be visualized every 8 hours minimum, to check power source every 4 hours and drainage and signs and symptoms of infection and inspect skin under tubing for break down every 8 and document per facility policy. 6. Current CNA staff are educated, and all future CAN staff will be educated to check wound vac for being charged/plugged in and if dressing is coming lose with each patient care contact. Patients who are mentally able will be educated to alert nursing staff if the machine becomes unplugged or does not appear to be pumping. All nursing staff have completed education and competency training. 7. If the wound vac malfunctions the dressing may be left in place for two hours. At this time the supplier will be notified of the need for stat delivery of a		

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F 686	Continued From page 3 care orders which caused worsening of R1's stage 4 sacral (a bone located at the base of your spine) ulcer and additional skin breakdown of 25.0 centimeters (cm) x 8.0 cm of previously good skin. The mismanagement of the wound vac and ulcer resulted in further necrosis (death of living tissue), infection, and hospitalization. A second Vulnerable Adult Maltreatment report submitted to the SA on 6/28/23 at 2:45 p.m., noted concerns regarding the facilities' ability to manage R1's stage 4 sacral ulcer and wound vac due to the deterioration of the ulcer while under their care resulting in R1's excess pain and long hospitalization stay. R1's Medical Diagnosis List last updated on 6/12/23, identified diagnoses of stage 4 pressure ulcer of sacrum, diabetes with polyneuropathy, severe chronic kidney disease, and heart failure. R1's hospital document titled, Discharge to Skilled Nursing Facility dated 6/12/23, identified an order for NWPT (wound vac) to sacral ulcer with further direction to use one large, black granufoam dressing, pack wound to skin level (including undermining). Recommended skin prep and 2-inch barrier ring to periwound skin and bridge wound up to hip, do not place trac pad over the wound or over any bony prominence. Change Monday, Wednesday, and Friday. Cleanse wound with saline or wound cleanser when dressing changed. Suction set at 125 mmHg continuous. The patient's NPWT device should be on at least 22 hours of every day. If there is a malfunction of the pump, trouble shooting failed, and suction is off for 2 hours, you should remove the foam packing from the wound and pack gauze moistened with saline or sterile	F 686	new wound pump. If wound vac is off/malfunctions for more than two hours the PCP will be called for directions on interim dressing of wound and new wound vac dressing applied when replacement pump arrives. Time of malfunction will be determined using every four-hour check and by CNA reporting of malfunction if present after each patient interaction. 8. An audit will be used to monitor two times a week for 2 weeks, then weekly x 2 weeks and then monthly x 3 The audit will be completed by the DNS, or RN designee with the results of the audits to the QAPI committee for further recommendations. Further education will be completed after each audit as applicable. Date: 8/4/2		

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F 686	Continued From page 4 water. Change this dressing twice daily until the dressing can be replaced. The patient education section included: *The canister is changed once/week or when it is full. R1's Hospital discharge orders dated 6/12/23, included the aforementioned treatment orders for the wound vac dressing change to the sacral ulcer. R1's Skin Wound Evaluation dated 6/12/23, included stage 4 pressure ulcer in the middle of the sacrum present on re-admission to the facility. The wound measured 7.2 cm in length, 6.2 cm wide, 6.5 cm deep, with 6.5 cm of undermining (wider area of breakdown under the wound opening) and no tunneling (forms passageways underneath the surface of the skin). The pressure ulcer showed no signs of infection. Surrounding tissue is fragile skin and risk for breakdown. Primary dressing was wound vac. No further assessment of the sacral wound was identified. R1's Braden Assessment dated 6/12/23, indicated R1 was at mild risk for pressure ulcers. R1's admission Minimum Data Set (MDS) dated 6/16/23, indicated R1 had severe cognitive impairment. Required extensive assist of staff for bed mobility, dressing, toileting, repositioning, transferring, and mobility. R1 was occasionally incontinent of bowel and had a urinary catheter. R1 was identified to be at risk for pressure ulcers. R1 had one stage four pressure ulcer, one venous ulcer, and one surgical wound. The MDS identified the following interventions were in place: pressure reducing device for chair and bed, turning and repositioning program,			F 686			

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F 686	Continued From page 5 nutrition/hydration intervention to manage skin problems, pressure ulcer/injury care, application of non-surgical dressings, applications of ointments/medications to feet and areas other than to the feet. R1's Care Plan initiated on 6/14/23, indicated R1 had a stage 4 pressure ulcer to sacrum related to immobility, left hemiplegia, polyneuropathy. Interventions included administer treatments as ordered and monitor for effectiveness; avoid positioning the resident on back; monitor nutritional status; serve diet as ordered; monitor and record intake; the resident needs assistance to turn/reposition every two hours or more often as needed or requested; up in chair for no more than 1 ½ to 2 hours; air mattress to bed and cushion in chair, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. R1's care plan did not address interventions or direction for the wound vac. R1's Nurse-Readmission Assessment dated 6/19/23, indicated R1 was readmitted from the hospital on 6/12/23. The assessment identified R1 had a pressure ulcer on the sacrum that required a wound vac. The assessment did not include wound measurements, drainage, pain presence, periwound skin integrity, or wound vac function. The assessment further indicated R1 had an alternating air mattress. Facility Negative Pressure Wound Therapy policy dated 2014, directed the following: NPWT is contraindicated in residents who have wounds with necrotic tissue with eschar, untreated osteomyelitis, non-enteric fistula or a malignancy.			F 686			

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F 686	Continued From page 6 Documentation: 1. The wound status at time of application of negative pressure. 4. The resident's tolerance of the procedure. 6. The date and time negative pressure therapy was started and stopped. Reporting: 1. any problems with procedure. 2. Marked changes in the wound from baseline or previous dressing change. Physician order dated 6/14/23 included a wound clinic referral. R1's Treatment Administration Record (TAR) identified the wound vac dressing change order that directed to change R1's wound vac three times a week on Monday, Wednesday, and Friday. R1's dressing changes were completed on 6/14/23 by registered nurse (RN)-A. On 6/16/23, the dressing change was marked completed by the director of nursing (DON). On 6/19/23 and on 6/21/23, the TAR identified R1's dressing had not been changed and was marked with a chart code of "9" which indicated the treatment was not completed and directed to see progress notes. Progress notes dated 6/19/23 and 6/21/23 did not identify why the wound vac treatment was not completed. Review of R1's medical record from 6/12/23 to 6/16/23, did not include any routine monitoring for signs/symptoms of infection, amount of drainage including color, wound bed characteristics, and skin surrounding the pressure ulcer. There was no indication if R1 had any pain that was associated with wound vac placement or if the wound vac suction was set at 125 mmHg continuous at 22 hours every day as ordered by the physician. R1's progress note dated 6/16/23, at 2:30 p.m.			F 686			

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F 686	Continued From page 7 indicated R1 voiced coccyx area discomfort when sitting in her chair; the tubing and trac were directly over the wound was causing discomfort, she was assisted to bed which was helpful. R1 also has phantom limb pain and polyneuropathy pain. She had been administered as needed hydromorphone (narcotic pain medication) in the morning and scheduled Tylenol which were effective. R1 declined "stronger" pain medication at that time. In a subsequent note at 2:35 p.m. the physician was notified who then ordered Oxycodone (narcotic pain medication) 10 milligrams (mg) every 12 hours. R1's progress note dated 6/16/23, at 9:55 p.m. indicated R1 complained of almost constant pain from her sugical site on right stump and coccyx/sacrum area. R1 rated her pain 10 out of 10; she had non-verbal signs of pain "facial expressions and protective body movements that indicate pain as well." She recieved scheduled and as needed medications of hydromorphone, Tylenol, and Oxycodone. Repositioning and rest help to alleviate some of her pain as well. Although the TAR dated 6/16/23, identified R1's wound vac treatment was changed, it was not evident the pain evaluation included checking the placement and/or integrity of the wound dressing as a causal factor of R1's pain. After 6/16/23, R1's record identified the next progress note was a physican visit dated 6/21/23. R1's wound clinic After Visit Summary dated 6/21/23, indicated it was R1's initial visit. R1 received wound care services for ongoing management of ulcerations that included sacral stage 4 pressure ulcer. The note included	F 686			

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F 686	Continued From page 8 "Wound VAC dressings were removed from the sacrum. This was not applied properly." The dressing was to be bridged to one of R1's hips however, they (facility staff) had the plastic flange directly over R1's sacrum; there was not enough black foam exposed for the plastic flange to adhere. 200 milliliters (ml) of drainage in the canister. Measurements of the wound showed the ulcer measured 5.8 cm x 6.0 cm x 4.0 cm. Undermining noted throughout the wound; at the 12 o'clock position 3.5 cm, 1 o'clock 4.5 cm, 3 o'clock 3.0 cm, 6 o'clock 1.0 cm, and 9 o'clock 3.0 cm. Wound bed is roughly 2% necrotic tissue and 50% granular. No periwound erythema, induration, stricture, or fluctuance. The wound was debrided to the level of the muscle. The following detailed instructions were given for the NWPT dressing changes to the sacrum: Clean wound bed with gauze and wound cleanser Treat periwound with skin barrier prep Place transparent dressing in the periwound skin for protection, this should be draped up to her hip for bridging. Pack the wound with the black granufoam (be sure to pack all undermined areas) and bridge this up to the hip over the transparent dressing. Be sure that all of the black foam is touching and not in contact with R1's skin. Secure all down with another transparent drape Cut out a 1.0 cm hole over the bridged portion to expose the black foam Place the plastic flange over the exposed black foam Secure the plastic flange down with transparent strips Turn the wound vac on at -125 mmHg continuous pressure. Be sure there are no leaks. Change Monday, Wednesday, and Friday. The visit note further included: It is very important			F 686			

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F 686	Continued From page 9 that the wound vac is applied correctly and that it is bridged to the hip. Continue to check the wound vac through the day at least every shift or more often to be sure that there is a good seal and not malfunctioning. R1 should be on a pressure relieving mattress, change position ever 1-2 hours to reduce pressure to the sacrum. Plan is to see R1 at the facility next visit (6/26/23) as it would be beneficial to show the facility nursing staff how to place the wound vac appropriately for R1's safety. R1's care plan revised on 6/21/23, added the intervention of wound vac to sacral wound per orders. R1's TAR indicated registered nurse (RN)-A completed the wound vac dressing change to the sacral wound on 6/23/23. In review of R1's medical record between 6/17/23 to 6/26/23, the record did not include evidence of routine monitoring for signs/symptoms of infection, comprehensive wound assessments, evaluations for wound improvement or deterioration with dressing changes, and comprehensive pain assessment associated with wound vac placement. Additionally, not evident the wound vac was monitored for drainage amounts and continuous function. R1's Wound Care Follow Up Progress Notes written by nurse practitioner (NP)-A dated 6/26/23, indicated the wound team completed R1's visit at the facility with RN-A present. The note indicated R1 continued to have pain in the coccyx region. R1's dressing was "removed from the coccyx but unfortunately, when the foam was bridged to the hip, there was not transparency	F 686			

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F 686	Continued From page 10 drrape placed under the foam [as ordered] so it did cause skin damage and is quite irritated." No drainage in the wound vac canister and a moderate odor was noted to the wound. Wound bed is full thickness, 75% eschar/slough, 25% granular. The wound bed measures 6.5 cm x 5.5 cm x 4.0 cm with undermining noted of the entirety and exposed bone that is easily felt. "With appearance of wound on buttocks, vitals were obtained by nursing facility nurse, temp 100, blood pressure was not hypotensive, heart rate 86, respiratory rate 20. Mild temp, bone exposed, worsening wound erythema, advised that she should be seen in the emergency department. Likely will need imaging and lab work to rule out osteomyelitis and may need to see surgeon for bone debridement and wound debridement." R1 was sent to the emergency room for further evaluation. R1's facility progress note dated 6/27/23, indicated R1 had been transferred from the emergency room to a higher-level hospital and was receiving antibiotics. A follow up progress noted on 6/28/23, indicated R1 would not tolerate a surgery at that time and is getting debridement (a procedure to remove debris or infected/dead tissue from a wound) on the sacral wound. R1's social service note dated 7/11/23, indicated R1 would be discharged from the hospital on 7/12/23 after spending 16 days in the hospital for wound management. During an interview on 7/6/23 at 4:23 p.m., RN-A stated awareness of R1's wound vac dressing's being applied incorrectly. Further stated the facility had not provided any formal training but had worked with wound vacs at prior facilities.	F 686			

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F 686	Continued From page 11 Normal process is to check for drainage when you walk by, RN-A had not recorded the "checks", but stated it was something staff should be doing. During an interview on 7/10/23 at 11:30 a.m., contracted wound care certified medical assistant (MA)-A stated they first saw R1's wound on 6/21/23, at the wound care clinic. MA-A explained the wound vac dressing was done incorrectly; the tubing was placed directly over the sacral ulcer, the dressing was loose and not sealed adequately to allow for proper suction. MA-A indicated R1 was having a lot of pain at the time. R1's sacral dressing was replaced in the clinic and detailed instructions were provided to the facility on how to correctly change and bridge the dressing. MA-A stressed the black foam could not be on good skin because it would cause breakdown; the healthy skin needed to be protected by a transparent film. MA-A stated R1's next visit on 6/26/23, was at the facility. When taking off R1's dressing the black foam had been placed on healthy skin and caused skin irritation of about 25 centimeters(cm) x 8.0 cm and the bone was exposed so the nurse practitioner(NP)-A advised sending R1 to the emergency department (ED) as a result of the facility not provding adequate care and oversight of the wound vac. During an interview on 7/10/23 at 11:40 a.m., NP-A stated on R1's wound clinic visit on 6/21/23, the wound vac dressing was not applied the way the provider ordered it. The 6/26/23 visit was conducted at the facility so the facility staff could be educated on how to perform the dressing change according to the physician orders. NP-A explained the facility staff would have put the dressing on R1's wound on 6/23/23. When that	F 686			

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F 686	Continued From page 12 dressing was removed on 6/26/23, the dressing had been bridged but transparency film was not put down first to protect the health skin which caused R1 pain when removing the black foam. The area of R1's skin that was denuded (loss of skin caused by moisture and friction) measured 25.0 cm x 8.0 cm. Also noted exposed bone in the wound bed, necrotic (death of living tissue) skin, and elevated temperature which resulted in an order to transfer to the ED. During an interview on 6/26/23 at 5:16 p.m., RN-B indicated she and the DON had completed R1's wound vac sacral dressing changes twice but did not bridge it as ordered because there was no explanation why the bridging needed to be done. RN-B verified she did not contact the wound care clinic or surgeon to clarify the order. During an interview on 7/6/23 at 11:20 a.m., DON stated normally she completed wound rounds once a week which included documenting and taking a picture. The DON verified the facility nurses did not have any documented wound vac training in their personnel files. The DON stated she was made aware by the wound clinic team of missing the step of putting the barrier down and then not bridging correctly for R1's dressing change. The DON then identified the need for wound vac training so scheduled the wound vac supplier to train nurses on 7/17/23. R3's hospital After Visit Summary dated 7/1/23, indicated R3 was discharged to the facility following hospitalization for an abscess spinal epidural (infection in the spine) and laminectomy. This document included an order to leave wound vac on for 5 days and to change dressing pads	F 686			

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F 686	Continued From page 13 as needed. R3's admission MDS dated 7/8/23, indicated R3 did not have cognitive impairment. R3 required assist of two staff with bed mobility, transferring, dressing, toileting. R3 did not walk or get up in a wheelchair. R3 had one surgical wound. R3's Braden Scale for Predicting Pressure Sore Risk dated 7/1/23, indicated R3 was moderate risk for pressure sores. R3's wound vac physician order dated 7/5/23, directed to place incisional wound vac change every third day, take picture of incision with every change, set wound vac at 75 mmHg of continuous suction. R3's Care plan last updated 7/5/2, indicated R3 had a potential/actual impairment to skin integrity and identified interventions of barrier cream. The care plan lacks any documentation of R3's wound vac, management, and monitoring. R3's Skin and Wound Evaluation initially done on 7/10/23 at 10:39 a.m. (10 days after admission) identified R3 had a surgical wound closed with 15 sutures present upon admission to the facility. The surgical wound measured 7.3 cm long and 0.9 cm wide. The evaluation did not include any other wound characteristics such as drainage, presence/absence of signs/symptoms of infection, dressing type, or wound vac therapy. R3's July 2023 treatment administration record (TAR) did not identify the physician orders for wound vac dressing changes nor indicate the dressings had been completed per the physician order. Further in review of R3's medical record it	F 686			

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F 686	Continued From page 14 was not evident of ongoing monitoring for signs/symptoms of wound infection and not evident of ongoing monitoring of wound vac function and efficacy. During observation and interview on 7/6/23 at 2:30 p.m., R3 stated the wound vac had been unplugged and not working for an undetermined amount of time and had not heard the wound vac making suction noises since the previous day (7/5/23). No wound drainage observed in the wound vac drainage chamber. Family member (FM)-A stated the wall plug-ins were loose and it must have fallen out again. R3 stated no one checked her wound vac unless she asked them to and was still waiting for the new wound vac and dressing change. During an interview on 7/6/23 at 4:23 p.m., the DON was informed of R3's report and evaluator's observation of R3's wound vac being unplugged for an undetermined amount of time. The DON verified that staff did not routinely check the wound vac for proper functioning. DON had not been aware of R3's wound vac not working and would add a check for wound vac function to R3's treatment administration record. During observation on 7/6/23 at 5:32 p.m., RN-B and the DON changed R3's wound vac and dressing. DON was unable to get the camera to take a picture of the wound. No wound assessment was completed or documented by RN-B or the DON. The wound vac was observed to be functioning. During observation and interview on 7/10/23 at 10:14 a.m., FM-A stated R3's machine was noted to be unplugged the previous morning (7/9/23) at	F 686			

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F 686	Continued From page 15 8:00 a.m. and immediately plugged it in and it started to suction. FM-A did not know how long the wound vac had been unplugged and R3 stated she was not aware the wound vac was unplugged until FM-A told her. A small amount of drainage was observed in the wound vac tubing. During an observation on 7/10/23 at 10:30 a.m., RN-A and licensed practical nurse (LPN)-A changed R3's wound dressing. R3 told RN-A that a picture was supposed to be taken of the wound with the dressing change. RN-A left the room to get the tablet computer. RN-A stated the camera on the tablet automatically measured the wound but if the camera was not functioning, they were to manually measure the wound, and document in the medical record. RN-A verified the wound vac was not functioning properly at 140 mmHg (which was not consistent with the physician order that directed 75 mmHg) RN-A then left R3's room. RN-A stated she was unsure of the battery life of the wound vac, there was an instruction book on the wound vacs but was not sure where it was located and would have to check with the DON. During a follow up interview on 7/10/23 at 11:31 a.m., RN-A verified R3's wound vac was set at 140 mmHg of pressure but thought it was supposed to be set at 125 mmHg. After checking with the DON, RN-A stated the physician order was for 75 mmHg and would change the settings immediately. During an interview on 7/10/23 at 11:40 a.m., NP-A indicated a wound vac setting of 140 mmHg causes more suction and could cause increased pain. Recommendation was to start with a lower pressure setting as most people can't tolerate a	F 686			

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F 686	Continued From page 16 setting of 140 mmHg. During an interview on 7/10/23 at 12:09 p.m., DON verified wound measurements and assessment were not done on R3 during the 7/6/23, dressing change. DON stated she was unsure of how the suction setting would have been changed on R3's wound vac and unaware that it had been unplugged. Interview on 7/11/23 at 2:12 p.m., the Administrator stated wound vacs were new to the facility within the past month and anytime there is something new like that (wound vacs) there needs to be education. The facility policy titled, Negative Pressure Wound Therapy, last revised 2/2014 directs to assess the wound prior to selecting the type, size, and thickness of dressing material. Create a barrier dressing to protect healthy skin; there should be at least a 1-inch barrier around the margins of the wound. Initiate negative pressure settings on the pump as ordered. Document in the resident's medical record the wound status at the time of application of negative pressure, the number of sponge pieces used in the wound dressing, the negative pressure and time settings on the pump, and the resident's tolerance of the procedure, the date and time of the dressing application/change, the date and time negative pressure therapy was started and stopped, the names and initials of the person performing the dressing change. The immediate jeopardy that began on 6/12/23, was removed on 7/12/23, when it could be verified the facility implemented the following;	F 686			

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F 686	Continued From page 17	F 686			
F 726 SS=D	-Reviewed facility policy/procedures for wound vac and wound care -Identified residents who were at risk, completed comprehensive wound assessments, reviewed/revised care plans and physician orders according to assessments. -Nursing staff were provided with Wound Vac training and demonstrated competency. Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and	F 726			8/10/23

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F 726	Continued From page 18 techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure competent nurse staffing for wound vac management and dressing changes for 2 of 3 residents (R1 and R3) with a wound vac (negative pressure wound therapy), Findings include R1's Medical Diagnosis List last updated on 6/12/23, identified diagnoses of stage 4 pressure ulcer of sacrum. R1's admission Minimum Data Set (MDS) dated 6/16/23, indicated R1 had severe cognitive impairment. R1 had one stage four pressure ulcer. The MDS identified intervention for pressure ulcer/injury care. R1's Care Plan initiated on 6/14/23, indicated R1 had a pressure ulcer development related to stage 4 pressure ulcer to sacrum. The care plan did not address R3's wound vac, management, and monitoring. R1's document titled, hospital Wound Care Follow Up Progress Notes written by nurse practitioner (NP)-A dated 6/26/23, indicated the wound team completed R1's visit at the facility with RN-A present. R1's dressing was removed from the coccyx but unfortunately, when the foam was bridged to the hip, there was not transparency drape placed under the foam as ordered so it did cause skin damage and is quite	F 726	F686 ☐ Treatment to Prevent/Heal Pressure Injuries 1. R1, R2, R3, and R4 have the potential to a serious adverse outcome. No other residents were identified. 2. All residents with wound vac have the potential to be affected in this area. 3. Facility Wound Vac Policy updated to reflect PCC wound assessment will be completed Weekly on scheduled day placed on MAR and when changes in wound are observed with scheduled dressing change. PCC assessment includes photo of wound, measurements, and wound assessment. If dressing needed between scheduled dressing changes a PCC wound assessment will be done prn with changes in wound status. 4. Wound assessments per PCC wound program will be completed at a minimum of a schedule weekly and PRN with any wound changes, care plans to reflect wound vac use and orders updated to check settings & power source every four hours and document on TAR. Wound Vac machines have an alarm for 15 minutes of battery left to alert staff of low charge. Drainage and for signs and symptoms of infections and observation of skin under tubing order will be placed in TAR to be checked and documented every 8 hours. 5. Policy updates completed after		

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F 726	Continued From page 19 irritated. No drainage in the wound vac canister and a moderate odor was noted to the wound. The wound bed measures 6.5 cm x 5.5 cm x 4.0 cm with undermining noted of the entirety and exposed bone that is easily felt. R1 required a transfer to the emergency department at that time due to a mild temperature (100.0 Fahrenheit), exposed bone, and worsening wound erythema to rule out osteomyelitis and may need to see a surgeon for bone debridement and wound debridement. During an interview on 7/10/23 at 11:30 a.m., contracted wound care certified medical assistant (MA)-A stated they first saw R1's wound on 6/21/23, at the wound care clinic. MA-A explained the wound vac dressing was done incorrectly; the tubing was placed directly over the sacral ulcer, the dressing was loose and not sealed adequately to allow for proper suction. MA-A indicated R1 was having a lot of pain at the time. R1's sacral dressing was replaced in the clinic and detailed instructions were provided to the facility on how to correctly change and bridge the dressing. MA-A stressed the black foam could not be on good skin because it would cause breakdown; the healthy skin needed to be protected by a transparent film. MA-A stated R1's next visit on 6/26/23, was at the facility. When taking off R1's dressing the black foam had been placed on healthy skin and caused skin irritation of about 25 centimeters(cm) x 8.0 cm and the bone was exposed so the nurse practitioner(NP)-A advised sending R1 to the emergency department (ED). During an interview on 7/10/23 at 11:40 a.m., NP-A stated on R1's wound clinic visit on 6/21/23, the wound vac dressing was not applied the way	F 726	discussion with wound vac educator. Wounds vac areas of all residents affected will be visualized every 8 hours minimum, to check power source every 4 hours and drainage and signs and symptoms of infection and inspect skin under tubing for break down every 8 and document per facility policy. 6. Current CNA staff are educated, and all future CAN staff will be educated to check wound vac for being charged/plugged in and if dressing is coming lose with each patient care contact. Patients who are mentally able will be educated to alert nursing staff if the machine becomes unplugged or does not appear to be pumping. All nursing staff have completed education and competency training. Wound vac training and competency will be completed yearly and with orientation. 7. If the wound vac malfunctions the dressing may be left in place for two hours. At this time the supplier will be notified of the need for stat delivery of a new wound pump. If wound vac is off/malfunctions for more than two hours the PCP will be called for directions on interim dressing of wound and new wound vac dressing applied when replacement pump arrives. Time of malfunction will be determined using every four-hour check and by CNA reporting of malfunction if present after each patient interaction. 8. An audit will be used to monitor two times a week for 2 weeks, then weekly x 2 weeks and then monthly x 3 The audit will be completed by the DNS, or RN designee with the results of the audits to		

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F 726	Continued From page 20 the provider ordered it. The 6/26/23 visit was conducted at the facility so the facility staff could be educated on how to perform the dressing change according to the physician orders. NP-A explained the facility staff would have put the dressing on R1's wound on 6/23/23. When that dressing was removed on 6/26/23, the dressing had been bridged but transparency film was not put down first to protect the health skin which caused R1 pain when removing the black foam. The area of R1's skin that was denuded (loss of skin caused by moisture and friction) measured 25.0 cm x 8.0 cm. Also noted exposed bone in the wound bed, necrotic (death of living tissue) skin, and elevated temperature which resulted in an order to transfer to the ED. R3's document titled, After Visit Summary (Facility) dated 7/1/23, indicates R1 was discharged to the facility following hospitalization for an abscess spinal epidural (infection in the spine) and laminectomy. R3's admission MDS dated 7/8/23, indicated R3 did not have cognitive impairment. R3 had one surgical wound. R3's care plan last updated 7/5/23, did not address R3's wound vac, management, and monitoring. During observation and interview on 7/6/23 at 2:30 p.m., R3 stated the wound vac had been unplugged and not working for an undetermined amount of time and had not heard the wound vac making suction noises since the previous day. No wound drainage observed in the wound vac drainage chamber. Family member (FM)-A stated the wall plug-ins were loose and it must	F 726	the QAPI committee for further recommendations. Further education will be completed after each audit as applicable. Date: 8/4/2		

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F 726	Continued From page 21 have fallen out again. R3 stated no one checks her wound vac unless she asks them to and is still waiting for the new wound vac and dressing change. During an interview on 7/6/23 at 4:23 p.m., the DON was informed of R3's report and evaluator's observation of R3's wound vac being unplugged for an undetermined amount of time. The DON verified that staff did not routinely check the wound vac for proper functioning and she had not been aware of R3's wound vac not working and would add a check for wound vac function to R3's treatment administration record. During observation and interview on 7/10/23 at 10:14 a.m., FM-A stated R3's machine was noted to be unplugged the previous morning at 8:00 a.m. and immediately plugged it in and it started to suction. FM-A did not know how long the wound vac had been unplugged and R3 stated she was not aware the wound vac was unplugged until FM-A told her. A small amount of drainage was observed in the wound vac tubing. During an observation on 7/10/23 at 10:30 a.m., RN-A and licensed practical nurse (LPN)-A changed R3's wound dressing. R3 told RN-A that a picture was supposed to be taken of the wound with the dressing change. RN-A left the room to get the tablet personal computer then RN-A stated the camera on the tablet automatically measures the wound but if the camera was not functioning, they were to manually measure the wound, and document in the medical record. RN-A verified the wound vac was not functioning properly at 140 mmHg (which was not consistent with the physician order that directed 75 mmHg) RN-A then left R3's room. RN-A stated she was	F 726			

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F 726	Continued From page 22 unsure of the battery life of the wound vac, there was an instruction book on the wound vacs but was not sure where it was located and would have to check with the DON. During a follow up interview on 7/10/23 at 11:31 a.m., RN-A verified R3's wound vac was set at 140 mmHg of pressure but thought it was supposed to be set at 125 mmHg but would check with the DON. After checking with the DON, RN-A stated the physician order was for 75 mmHg and would change the settings immediately. During an interview on 7/10/23 at 11:40 a.m., NP-A indicated a wound vac setting of 140 mmHg causes more suction and could cause increased pain. Recommendation was to start with a lower pressure setting as most people can't tolerate a setting of 140 mmHg. During an interview on 7/6/23 at 3:13 p.m., trained medication aide (TMA)-A stated not knowing anything about the function of wound vacs. During an interview on 7/6/23 at 3:18 p.m., nursing assistant (NA)-A stated not knowing much about the wound vac except staff needed to be careful with it, if the vac beeped the nurse was supposed to be notified. During an interview on 7/6/23 at 3:23 p.m., NA-B stated she did not receive any real training on the wound vac but listened for the sucking sound. If the vac seemed like it was leaking, she would get the nurse. During an interview on 7/6/23 at 3:32 p.m., NA-C	F 726			

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F 726	Continued From page 23 stated did not know anything about the wound vacs except to be careful with them. During an interview on 7/5/2023 at 4:25 p.m., LPN-A stated previous experience at a different facility but had not received any formal training and no training from the facility on wound vacs or dressing changes. During an interview on 7/6/23 at 11:20 a.m., DON stated normally she does wound rounds on residents once a week which includes documenting and taking a picture. The DON verified the facility nurses did not have any documented wound vac training in their personnel files. The DON further verified she was made aware by the wound clinic team R1's dressing was not appropriately applied. The DON then identified the need for wound vac training so scheduled the wound vac supplier to train nurses on 7/17/23. During an interview on 7/11/23 at 2:12 p.m., the Administrator stated wound vacs were new to the facility within the past month and anytime there is something new like that (wound vacs) there needed to be education. Facility Assessment dated 8/10/2022, in section 1.3 The assessment indicated the facility had the human and material resources necessary to meet the needs of residents who had skin ulcers, wounds, and injuries. Section 2.1 Services and Care We Offer Based on our Resident's needs indicated the facility provided pressure injury prevention and care, skin care, wound care (surgical, other skin wounds), Section 3.4. Competencies: Specialized care	F 726			

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F 726	Continued From page 24 including wound care/dressings.	F 726			

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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 7/5/23, 7/6/23, 7/10/23, 7/11/23, and 7/12/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

08/04/23

Minnesota Department of Health

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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
2 000	Continued From page 1 when they will be completed. The following complaints were reviewed: H54003321C (MN00094857 and MN00094907) and H54003412C (MN00094867) with a licensing order issued at 0300 and 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor 's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000			

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000			
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure competent nurse staffing for wound vac management and dressing changes for 2 of 3 residents (R1 and R3) with a wound vac (negative pressure wound therapy), Findings include R1's Medical Diagnosis List last updated on 6/12/23, identified diagnoses of stage 4 pressure ulcer of sacrum. R1's admission Minimum Data Set (MDS) dated 6/16/23, indicated R1 had severe cognitive impairment. R1 had one stage four pressure ulcer. The MDS identified intervention for pressure ulcer/injury care.	2 300	F686 ☐ Treatment to Prevent/Heal Pressure Injuries 1. R1, R2, R3, and R4 have the potential to a serious adverse outcome. No other residents were identified. 2. All residents with wound vac have the potential to be affected in this area. 3. Facility Wound Vac Policy updated to reflect PCC wound assessment will be completed Weekly on scheduled day placed on MAR and when changes in wound are observed with scheduled dressing change. PCC assessment includes photo of wound, measurements, and wound assessment. If dressing needed between scheduled dressing changes a PCC wound assessment will be		8/10/23

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2 300	Continued From page 3 R1's Care Plan initiated on 6/14/23, indicated R1 had a pressure ulcer development related to stage 4 pressure ulcer to sacrum. The care plan did not address R3's wound vac, management, and monitoring. R1's document titled, hospital Wound Care Follow Up Progress Notes written by nurse practitioner (NP)-A dated 6/26/23, indicated the wound team completed R1's visit at the facility with RN-A present. R1's dressing was removed from the coccyx but unfortunately, when the foam was bridged to the hip, there was not transparency drape placed under the foam as ordered so it did cause skin damage and is quite irritated. No drainage in the wound vac canister and a moderate odor was noted to the wound. The wound bed measures 6.5 cm x 5.5 cm x 4.0 cm with undermining noted of the entirety and exposed bone that is easily felt. R1 required a transfer to the emergency department at that time due to a mild temperature (100.0 Fahrenheit), exposed bone, and worsening wound erythema to rule out osteomyelitis and may need to see a surgeon for bone debridement and wound debridement. During an interview on 7/10/23 at 11:30 a.m., contracted wound care certified medical assistant (MA)-A stated they first saw R1's wound on 6/21/23, at the wound care clinic. MA-A explained the wound vac dressing was done incorrectly; the tubing was placed directly over the sacral ulcer, the dressing was loose and not sealed adequately to allow for proper suction. MA-A indicated R1 was having a lot of pain at the time. R1's sacral dressing was replaced in the clinic and detailed instructions were provided to the facility on how to correctly change and bridge the	2 300	done prn with changes in wound status. 4. Wound assessments per PCC wound program will be completed at a minimum of a schedule weekly and PRN with any wound changes, care plans to reflect wound vac use and orders updated to check settings & power source every four hours and document on TAR. Wound Vac machines have an alarm for 15 minutes of battery left to alert staff of low charge. Drainage and for signs and symptoms of infections and observation of skin under tubing order will be placed in TAR to be checked and documented every 8 hours. 5. Policy updates completed after discussion with wound vac educator. Wounds vac areas of all residents affected will be visualized every 8 hours minimum, to check power source every 4 hours and drainage and signs and symptoms of infection and inspect skin under tubing for break down every 8 and document per facility policy. 6. Current CNA staff are educated, and all future CAN staff will be educated to check wound vac for being charged/plugged in and if dressing is coming lose with each patient care contact. Patients who are mentally able will be educated to alert nursing staff if the machine becomes unplugged or does not appear to be pumping. All nursing staff have completed education and competency training. Wound vac training will occur yearly and with orientation. 7. If the wound vac malfunctions the dressing may be left in place for two hours. At this time the supplier will be notified of the need for stat delivery of a new wound pump. If wound vac is	

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2 300	Continued From page 4 dressings. MA-A stressed the black foam could not be on good skin because it would cause breakdown; the healthy skin needed to be protected by a transparent film. MA-A stated R1's next visit on 6/26/23, was at the facility. When taking off R1's dressing the black foam had been placed on healthy skin and caused skin irritation of about 25 centimeters(cm) x 8.0 cm and the bone was exposed so the nurse practitioner(NP)-A advised sending R1 to the emergency department (ED). During an interview on 7/10/23 at 11:40 a.m., NP-A stated on R1's wound clinic visit on 6/21/23, the wound vac dressing was not applied the way the provider ordered it. The 6/26/23 visit was conducted at the facility so the facility staff could be educated on how to perform the dressing change according to the physician orders. NP-A explained the facility staff would have put the dressing on R1's wound on 6/23/23. When that dressing was removed on 6/26/23, the dressing had been bridged but transparency film was not put down first to protect the healthy skin which caused R1 pain when removing the black foam. The area of R1's skin that was denuded (loss of skin caused by moisture and friction) measured 25.0 cm x 8.0 cm. Also noted exposed bone in the wound bed, necrotic (death of living tissue) skin, and elevated temperature which resulted in an order to transfer to the ED. R3's document titled, After Visit Summary (Facility) dated 7/1/23, indicates R1 was discharged to the facility following hospitalization for an abscess spinal epidural (infection in the spine) and laminectomy. R3's admission MDS dated 7/8/23, indicated R3 did not have cognitive impairment. R3 had one	2 300	off/malfunctions for more than two hours the PCP will be called for directions on interim dressing of wound and new wound vac dressing applied when replacement pump arrives. Time of malfunction will be determined using every four-hour check and by CNA reporting of malfunction if present after each patient interaction. 8. An audit will be used to monitor two times a week for 2 weeks, then weekly x 2 weeks and then monthly x 3 The audit will be completed by the DNS, or RN designee with the results of the audits to the QAPI committee for further recommendations. Further education will be completed after each audit as applicable. Date: 8/4/2		

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2 300	Continued From page 5 surgical wound. R3's care plan last updated 7/5/23, did not address R3's wound vac, management, and monitoring. During observation and interview on 7/6/23 at 2:30 p.m., R3 stated the wound vac had been unplugged and not working for an undetermined amount of time and had not heard the wound vac making suction noises since the previous day. No wound drainage observed in the wound vac drainage chamber. Family member (FM)-A stated the wall plug-ins were loose and it must have fallen out again. R3 stated no one checks her wound vac unless she asks them to and is still waiting for the new wound vac and dressing change. During an interview on 7/6/23 at 4:23 p.m., the DON was informed of R3's report and evaluator's observation of R3's wound vac being unplugged for an undetermined amount of time. The DON verified that staff did not routinely check the wound vac for proper functioning and she had not been aware of R3's wound vac not working and would add a check for wound vac function to R3's treatment administration record. During observation and interview on 7/10/23 at 10:14 a.m., FM-A stated R3's machine was noted to be unplugged the previous morning at 8:00 a.m. and immediately plugged it in and it started to suction. FM-A did not know how long the wound vac had been unplugged and R3 stated she was not aware the wound vac was unplugged until FM-A told her. A small amount of drainage was observed in the wound vac tubing. During an observation on 7/10/23 at 10:30 a.m.,	2 300			

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2 300	Continued From page 6 RN-A and licensed practical nurse (LPN)-A changed R3's wound dressing. R3 told RN-A that a picture was supposed to be taken of the wound with the dressing change. RN-A left the room to get the tablet personal computer then RN-A stated the camera on the tablet automatically measures the wound but if the camera was not functioning, they were to manually measure the wound, and document in the medical record. RN-A verified the wound vac was not functioning properly at 140 mmHg (which was not consistent with the physician order that directed 75 mmHg) RN-A then left R3's room. RN-A stated she was unsure of the battery life of the wound vac, there was an instruction book on the wound vacs but was not sure where it was located and would have to check with the DON. During a follow up interview on 7/10/23 at 11:31 a.m., RN-A verified R3's wound vac was set at 140 mmHg of pressure but thought it was supposed to be set at 125 mmHg but would check with the DON. After checking with the DON, RN-A stated the physician order was for 75 mmHg and would change the settings immediately. During an interview on 7/10/23 at 11:40 a.m., NP-A indicated a wound vac setting of 140 mmHg causes more suction and could cause increased pain. Recommendation was to start with a lower pressure setting as most people can't tolerate a setting of 140 mmHg. During an interview on 7/6/23 at 3:13 p.m., trained medication aide (TMA)-A stated not knowing anything about the function of wound vacs. During an interview on 7/6/23 at 3:18 p.m.,	2 300			

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2 300	Continued From page 7 nursing assistant (NA)-A stated not knowing much about the wound vas except staff needed to be careful with it, if the vac beeped the nurse was supposed to be notified. During an interview on 7/6/23 at 3:23 p.m., NA-B stated she did not receive any real training on the wound vac but listened for the sucking sound. If the vac seemed like it was leaking, she would get the nurse. During an interview on 7/6/23 at 3:32 p.m., NA-C stated did not know anything about the wound vacs except to be careful with them. During an interview on 7/5/2023 at 4:25 p.m., LPN-A stated previous experience at a different facility but had not received any formal training and no training from the facility on wound vacs or dressing changes. During an interview on 7/6/23 at 11:20 a.m., DON stated normally she does wound rounds on residents once a week which includes documenting and taking a picture. The DON verified the facility nurses did not have any documented wound vac training in their personnel files. The DON further verified she was made aware by the wound clinic team R1's dressing was not appropriately applied. The DON then identified the need for wound vac training so scheduled the wound vac supplier to train nurses on 7/17/23. During an interview on 7/11/23 at 2:12 p.m., the Administrator stated wound vacs were new to the facility within the past month and anytime there is something new like that (wound vacs) there needed to be education.	2 300			

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2 300	Continued From page 8 Facility Assessment dated 8/10/2022, in section 1.3 The assessment indicated the facility had the human and material resources necessary to meet the needs of residents who had skin ulcers, wounds, and injuries. Section 2.1 Services and Care We Offer Based on our Resident's needs indicated the facility provided pressure injury prevention and care, skin care, wound care (surgical, other skin wounds), Section 3.4. Competencies: Specialized care including wound care/dressings. 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 areas 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: Twenty-one (21) days.	2 300			
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop	2 900			8/10/23

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2 900	Continued From page 9 pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete comprehensive pressure ulcer assessments and ensure physician ordered wound vac therapy was adequately managed for 2 of 3 residents (R1, R3) who required wound vac therapy. The facility's failures resulted in an immediate jeopardy (IJ) for R1's when their pressure ulcer deteriorated resulting in necrosis, bone exposure and hospitalization. The immediate jeopardy began on 6/26/23, when wound clinic identified R1's wound had deteriorated to the bone from improper dressing placement and mismanagement of the wound vac. The IJ was identified on 7/10/23 and the administrator, assistant administrator, and director of nursing (DON) were notified of the IJ on 7/10/23 at 5:45 p.m. The immediate jeopardy was removed on 7/12/23, but noncompliance remained at the lower scope and severity level of D- isolated with no more than minimal harm that is not immediate jeopardy. Findings include: Stage 4 pressure ulcer as defined by the State Operation Manual, last updated 11/22, is	2 900	F686 ☐ Treatment to Prevent/Heal Pressure Injuries 1. R1, R2, R3, and R4 have the potential to a serious adverse outcome. No other residents were identified. 2. All residents with wound vac have the potential to be affected in this area. 3. Facility Wound Vac Policy updated to reflect PCC wound assessment will be completed Weekly on scheduled day placed on MAR and when changes in wound are observed with scheduled dressing change. PCC assessment includes photo of wound, measurements, and wound assessment. If dressing needed between scheduled dressing changes a PCC wound assessment will be done prn with changes in wound status. 4. Wound assessments per PCC wound program will be completed at a minimum of a schedule weekly and PRN with any wound changes, care plans to reflect wound vac use and orders updated to check settings & power source every four hours and document on TAR. Wound Vac machines have an alarm for 15 minutes of battery left to alert staff of low charge.		

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2 900	Continued From page 10 full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. Negative Pressure Wound Therapy (NWPT) also known as a wound vac helps to heal wounds by providing a moist environment, promote new tissue formation, and removing excess fluid and infection. Negative pressure wound therapy uses suction, tubing, and wound dressing to remove excess exudate and any infectious material that may be present in the wound. Negative pressure wound therapy, also called "wound vac" or "NPWT," provides an ideal and clean environment to promote wound healing in acute or chronic wounds. Offering significant clinical benefits for large, chronic wounds and acute, complicated wounds, negative pressure wound therapy is used by healthcare teams and wound care specialists to support faster wound healing. The negative pressure or vacuum suction is provided by a pump that is connected to a wound. A foam dressing is placed in the wound and covered with an occlusive dressing. The fluid that is removed is collected in a canister on the pump. A Vulnerable Adult Maltreatment report submitted to the state agency (SA) on 6/27/23 at 9:10 a.m., indicated the facility incorrectly followed wound care orders which caused worsening of R1's stage 4 sacral (a bone located at the base of your spine) ulcer and additional skin breakdown of 25.0 centimeters (cm) x 8.0 cm of previously good skin. The mismanagement of the wound vac and ulcer resulted in further necrosis (death of living tissue), infection, and hospitalization. A second Vulnerable Adult Maltreatment report submitted to the SA on 6/28/23 at 2:45 p.m., noted concerns regarding the facilities' ability to	2 900	Drainage and for signs and symptoms of infections and observation of skin under tubing order will be placed in TAR to be checked and documented every 8 hours. 5. Policy updates completed after discussion with wound vac educator. Wounds vac areas of all residents affected will be visualized every 8 hours minimum, to check power source every 4 hours and drainage and signs and symptoms of infection and inspect skin under tubing for break down every 8 and document per facility policy. 6. Current CNA staff are educated, and all future CAN staff will be educated to check wound vac for being charged/plugged in and if dressing is coming lose with each patient care contact. Patients who are mentally able will be educated to alert nursing staff if the machine becomes unplugged or does not appear to be pumping. All nursing staff have completed education and competency training. Wound vac training will occur yearly and with orientation. 7. If the wound vac malfunctions the dressing may be left in place for two hours. At this time the supplier will be notified of the need for stat delivery of a new wound pump. If wound vac is off/malfunctions for more than two hours the PCP will be called for directions on interim dressing of wound and new wound vac dressing applied when replacement pump arrives. Time of malfunction will be determined using every four-hour check and by CNA reporting of malfunction if present after each patient interaction. 8. An audit will be used to monitor two times a week for 2 weeks, then weekly x 2		

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2 900	Continued From page 11 manage R1's stage 4 sacral ulcer and wound vac due to the deterioration of the ulcer while under their care resulting in R1's excess pain and long hospitalization stay. R1's Medical Diagnosis List last updated on 6/12/23, identified diagnoses of stage 4 pressure ulcer of sacrum, diabetes with polyneuropathy, severe chronic kidney disease, and heart failure. R1's hospital document titled, Discharge to Skilled Nursing Facility dated 6/12/23, identified an order for NWPT (wound vac) to sacral ulcer with further direction to use one large, black granufoam dressing, pack wound to skin level (including undermining). Recommended skin prep and 2-inch barrier ring to periwound skin and bridge wound up to hip, do not place trac pad over the wound or over any bony prominence. Change Monday, Wednesday, and Friday. Cleanse wound with saline or wound cleanser when dressing changed. Suction set at 125 mmHg continuous. The patient's NPWT device should be on at least 22 hours of every day. If there is a malfunction of the pump, trouble shooting failed, and suction is off for 2 hours, you should remove the foam packing from the wound and pack gauze moistened with saline or sterile water. Change this dressing twice daily until the dressing can be replaced. The patient education section included: *The canister is changed once/week or when it is full. R1's Hospital discharge orders dated 6/12/23, included the aforementioned treatment orders for the wound vac dressing change to the sacral ulcer. R1's Skin Wound Evaluation dated 6/12/23, included stage 4 pressure ulcer in the middle of	2 900	weeks and then monthly x 3 The audit will be completed by the DNS, or RN designee with the results of the audits to the QAPI committee for further recommendations. Further education will be completed after each audit as applicable. Date: 8/4/2		

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2 900	Continued From page 12 the sacrum present on re-admission to the facility. The wound measured 7.2 cm in length, 6.2 cm wide, 6.5 cm deep, with 6.5 cm of undermining (wider area of breakdown under the wound opening) and no tunneling (forms passageways underneath the surface of the skin). The pressure ulcer showed no signs of infection. Surrounding tissue is fragile skin and risk for breakdown. Primary dressing was wound vac. No further assessment of the sacral wound was identified. R1's Braden Assessment dated 6/12/23, indicated R1 was at mild risk for pressure ulcers. R1's admission Minimum Data Set (MDS) dated 6/16/23, indicated R1 had severe cognitive impairment. Required extensive assist of staff for bed mobility, dressing, toileting, repositioning, transferring, and mobility. R1 was occasionally incontinent of bowel and had a urinary catheter. R1 was identified to be at risk for pressure ulcers. R1 had one stage four pressure ulcer, one venous ulcer, and one surgical wound. The MDS identified the following interventions were in place: pressure reducing device for chair and bed, turning and repositioning program, nutrition/hydration intervention to manage skin problems, pressure ulcer/injury care, application of non-surgical dressings, applications of ointments/medications to feet and areas other than to the feet. R1's Care Plan initiated on 6/14/23, indicated R1 had a stage 4 pressure ulcer to sacrum related to immobility, left hemiplegia, polyneuropathy. Interventions included administer treatments as ordered and monitor for effectiveness; avoid positioning the resident on back; monitor nutritional status; serve diet as ordered; monitor	2 900			

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2 900	Continued From page 13 and record intake; the resident needs assistance to turn/reposition every two hours or more often as needed or requested; up in chair for no more than 1 ½ to 2 hours; air mattress to bed and cushion in chair, and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. R1's care plan did not address interventions or direction for the wound vac. R1's Nurse-Readmission Assessment dated 6/19/23, indicated R1 was readmitted from the hospital on 6/12/23. The assessment identified R1 had a pressure ulcer on the sacrum that required a wound vac. The assessment did not include wound measurements, drainage, pain presence, periwound skin integrity, or wound vac function. The assessment further indicated R1 had an alternating air mattress. Facility Negative Pressure Wound Therapy policy dated 2014, directed the following: NPWT is contraindicated in residents who have wounds with necrotic tissue with eschar, untreated osteomyelitis, non-enteric fistula or a malignancy. Documentation: 1. The wound status at time of application of negative pressure. 4. The resident's tolerance of the procedure. 6. The date and time negative pressure therapy was started and stopped. Reporting: 1. any problems with procedure. 2. Marked changes in the wound from baseline or previous dressing change. Physician order dated 6/14/23 included a wound clinic referral. R1's Treatment Administration Record (TAR) identified the wound vac dressing change order that directed to change R1's wound vac three	2 900			

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2 900	Continued From page 14 times a week on Monday, Wednesday, and Friday. R1's dressing changes were completed on 6/14/23 by registered nurse (RN)-A. On 6/16/23, the dressing change was marked completed by the director of nursing (DON). On 6/19/23 and on 6/21/23, the TAR identified R1's dressing had not been changed and was marked with a chart code of "9" which indicated the treatment was not completed and directed to see progress notes. Progress notes dated 6/19/23 and 6/21/23 did not identify why the wound vac treatment was not completed. Review of R1's medical record from 6/12/23 to 6/16/23, did not include any routine monitoring for signs/symptoms of infection, amount of drainage including color, wound bed characteristics, and skin surrounding the pressure ulcer. There was no indication if R1 had any pain that was associated with wound vac placement or if the wound vac suction was set at 125 mmHg continuous at 22 hours every day as ordered by the physician. R1's progress note dated 6/16/23, at 2:30 p.m. indicated R1 voiced coccyx area discomfort when sitting in her chair; the tubing and trac were directly over the wound was causing discomfort, she was assisted to bed which was helpful. R1 also has phantom limb pain and polyneuropathy pain. She had been administered as needed hydromorphone (narcotic pain medication) in the morning and scheduled Tylenol which were effective. R1 declined "stronger" pain medication at that time. In a subsequent note at 2:35 p.m. the physician was notified who then ordered Oxycodone (narcotic pain medication) 10 milligrams (mg) every 12 hours. R1's progress note dated 6/16/23, at 9:55 p.m.	2 900			

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2 900	Continued From page 15 indicated R1 complained of almost constant pain from her sugical site on right stump and coccyx/sacrum area. R1 rated her pain 10 out of 10; she had non-verbal signs of pain "facial expressions and protective body movements that indicate pain as well." She recieved scheduled and as needed medications of hydromorphone, Tylenol, and Oxycodone. Repositioning and rest help to alleviate some of her pain as well. Although the TAR dated 6/16/23, identified R1's wound vac treatment was changed, it was not evident the pain evaluation included checking the placement and/or integrity of the wound dressing as a causal factor of R1's pain. After 6/16/23, R1's record identified the next progress note was a physican visit dated 6/21/23. R1's wound clinic After Visit Summary dated 6/21/23, indicated it was R1's initial visit. R1 received wound care services for ongoing management of ulcerations that included sacral stage 4 pressure ulcer. The note included "Wound VAC dressings were removed from the sacrum. This was not applied properly." The dressing was to be bridged to one of R1's hips however, they (facility staff) had the plastic flange directly over R1's sacrum; there was not enough black foam exposed for the plastic flange to adhere. 200 milliliters (ml) of drainage in the canister. Measurements of the wound showed the ulcer measured 5.8 cm x 6.0 cm x 4.0 cm. Undermining noted throughout the wound; at the 12 o'clock position 3.5 cm, 1 o'clock 4.5 cm, 3 o'clock 3.0 cm, 6 o'clock 1.0 cm, and 9 o'clock 3.0 cm. Wound bed is roughly 2% necrotic tissue and 50% granular. No periwound erythema, induration, stricture, or fluctuance. The wound was debrided to the level of the muscle. The	2 900			

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2 900	Continued From page 16 following detailed instructions were given for the NWPT dressing changes to the sacrum: Clean wound bed with gauze and wound cleanser Treat periwound with skin barrier prep Place transparent dressing in the periwound skin for protection, this should be draped up to her hip for bridging. Pack the wound with the black granufoam (be sure to pack all undermined areas) and bridge this up to the hip over the transparent dressing. Be sure that all of the black foam is touching and not in contact with R1's skin. Secure all down with another transparent drape Cut out a 1.0 cm hole over the bridged portion to expose the black foam Place the plastic flange over the exposed black foam Secure the plastic flange down with transparent strips Turn the wound vac on at -125 mmHg continuous pressure. Be sure there are no leaks. Change Monday, Wednesday, and Friday. The visit note further included: It is very important that the wound vac is applied correctly and that it is bridged to the hip. Continue to check the wound vac through the day at least every shift or more often to be sure that there is a good seal and not malfunctioning. R1 should be on a pressure relieving mattress, change position ever 1-2 hours to reduce pressure to the sacrum. Plan is to see R1 at the facility next visit (6/26/23) as it would be beneficial to show the facility nursing staff how to place the wound vac appropriately for R1's safety. R1's care plan revised on 6/21/23, added the intervention of wound vac to sacral wound per orders. R1's TAR indicated registered nurse (RN)-A	2 900			

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2 900	Continued From page 17 completed the wound vac dressing change to the sacral wound on 6/23/23. In review of R1's medical record between 6/17/23 to 6/26/23, the record did not include evidence of routine monitoring for signs/symptoms of infection, comprehensive wound assessments, evaluations for wound improvement or deterioration with dressing changes, and comprehensive pain assessment associated with wound vac placement. Additionally, not evident the wound vac was monitored for drainage amounts and continuous function. R1's Wound Care Follow Up Progress Notes written by nurse practitioner (NP)-A dated 6/26/23, indicated the wound team completed R1's visit at the facility with RN-A present. The note indicated R1 continued to have pain in the coccyx region. R1's dressing was "removed from the coccyx but unfortunately, when the foam was bridged to the hip, there was not transparency drape placed under the foam [as ordered] so it did cause skin damage and is quite irritated." No drainage in the wound vac canister and a moderate odor was noted to the wound. Wound bed is full thickness, 75% eschar/slough, 25% granular. The wound bed measures 6.5 cm x 5.5 cm x 4.0 cm with undermining noted of the entirety and exposed bone that is easily felt. "With appearance of wound on buttocks, vitals were obtained by nursing facility nurse, temp 100, blood pressure was not hypotensive, heart rate 86, respiratory rate 20. Mild temp, bone exposed, worsening wound erythema, advised that she should be seen in the emergency department. Likely will need imaging and lab work to rule out osteomyelitis and may need to see surgeon for bone debridement and wound debridement." R1 was sent to the emergency room for further	2 900			

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2 900	Continued From page 18 evaluation. R1's facility progress note dated 6/27/23, indicated R1 had been transferred from the emergency room to a higher-level hospital and was receiving antibiotics. A follow up progress noted on 6/28/23, indicated R1 would not tolerate a surgery at that time and is getting debridement (a procedure to remove debris or infected/dead tissue from a wound) on the sacral wound. R1's social service note dated 7/11/23, indicated R1 would be discharged from the hospital on 7/12/23 after spending 16 days in the hospital for wound management. During an interview on 7/6/23 at 4:23 p.m., RN-A stated awareness of R1's wound vac dressing's being applied incorrectly. Further stated the facility had not provided any formal training but had worked with wound vacs at prior facilities. Normal process is to check for drainage when you walk by, RN-A had not recorded the "checks", but stated it was something staff should be doing. During an interview on 7/10/23 at 11:30 a.m., contracted wound care certified medical assistant (MA)-A stated they first saw R1's wound on 6/21/23, at the wound care clinic. MA-A explained the wound vac dressing was done incorrectly; the tubing was placed directly over the sacral ulcer, the dressing was loose and not sealed adequately to allow for proper suction. MA-A indicated R1 was having a lot of pain at the time. R1's sacral dressing was replaced in the clinic and detailed instructions were provided to the facility on how to correctly change and bridge the dressing. MA-A stressed the black foam could not be on good skin because it would cause breakdown; the healthy skin needed to be	2 900			

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2 900	Continued From page 19 protected by a transparent film. MA-A stated R1's next visit on 6/26/23, was at the facility. When taking off R1's dressing the black foam had been placed on healthy skin and caused skin irritation of about 25 centimeters(cm) x 8.0 cm and the bone was exposed so the nurse practitioner(NP)-A advised sending R1 to the emergency department (ED) as a result of the facility not provding adequate care and oversight of the wound vac. During an interview on 7/10/23 at 11:40 a.m., NP-A stated on R1's wound clinic visit on 6/21/23, the wound vac dressing was not applied the way the provider ordered it. The 6/26/23 visit was conducted at the facility so the facility staff could be educated on how to perform the dressing change according to the physician orders. NP-A explained the facility staff would have put the dressing on R1's wound on 6/23/23. When that dressing was removed on 6/26/23, the dressing had been bridged but transparency film was not put down first to protect the health skin which caused R1 pain when removing the black foam. The area of R1's skin that was denuded (loss of skin caused by moisture and friction) measured 25.0 cm x 8.0 cm. Also noted exposed bone in the wound bed, necrotic (death of living tissue) skin, and elevated temperature which resulted in an order to transfer to the ED. During an interview on 6/26/23 at 5:16 p.m., RN-B indicated she and the DON had completed R1's wound vac sacral dressing changes twice but did not bridge it as ordered because there was no explanation why the bridging needed to be done. RN-B verified she did not contact the wound care clinic or surgeon to clarify the order. During an interview on 7/6/23 at 11:20 a.m., DON	2 900			

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2 900	Continued From page 20 stated normally she completed wound rounds once a week which included documenting and taking a picture. The DON verified the facility nurses did not have any documented wound vac training in their personnel files. The DON stated she was made aware by the wound clinic team of missing the step of putting the barrier down and then not bridging correctly for R1's dressing change. The DON then identified the need for wound vac training so scheduled the wound vac supplier to train nurses on 7/17/23. R3's hospital After Visit Summary dated 7/1/23, indicated R3 was discharged to the facility following hospitalization for an abscess spinal epidural (infection in the spine) and laminectomy. This document included an order to leave wound vac on for 5 days and to change dressing pads as needed. R3's admission MDS dated 7/8/23, indicated R3 did not have cognitive impairment. R3 required assist of two staff with bed mobility, transferring, dressing, toileting. R3 did not walk or get up in a wheelchair. R3 had one surgical wound. R3's Braden Scale for Predicting Pressure Sore Risk dated 7/1/23, indicated R3 was moderate risk for pressure sores. R3's wound vac physician order dated 7/5/23, directed to place incisional wound vac change every third day, take picture of incision with every change, set wound vac at 75 mmHg of continuous suction. R3's Care plan last updated 7/5/2, indicated R3 had a potential/actual impairment to skin integrity and identified interventions of barrier cream. The	2 900			

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2 900	Continued From page 21 care plan lacks any documentation of R3's wound vac, management, and monitoring. R3's Skin and Wound Evaluation initially done on 7/10/23 at 10:39 a.m. (10 days after admission) identified R3 had a surgical wound closed with 15 sutures present upon admission to the facility. The surgical wound measured 7.3 cm long and 0.9 cm wide. The evaluation did not include any other wound characteristics such as drainage, presence/absence of signs/symptoms of infection, dressing type, or wound vac therapy. R3's July 2023 treatment administration record (TAR) did not identify the physician orders for wound vac dressing changes nor indicate the dressings had been completed per the physician order. Further in review of R3's medical record it was not evident of ongoing monitoring for signs/symptoms of wound infection and not evident of ongoing monitoring of wound vac function and efficacy. During observation and interview on 7/6/23 at 2:30 p.m., R3 stated the wound vac had been unplugged and not working for an undetermined amount of time and had not heard the wound vac making suction noises since the previous day (7/5/23). No wound drainage observed in the wound vac drainage chamber. Family member (FM)-A stated the wall plug-ins were loose and it must have fallen out again. R3 stated no one checked her wound vac unless she asked them to and was still waiting for the new wound vac and dressing change. During an interview on 7/6/23 at 4:23 p.m., the DON was informed of R3's report and evaluator's observation of R3's wound vac being unplugged for an undetermined amount of time. The DON	2 900			

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2 900	Continued From page 22 verified that staff did not routinely check the wound vac for proper functioning. DON had not been aware of R3's wound vac not working and would add a check for wound vac function to R3's treatment administration record. During observation on 7/6/23 at 5:32 p.m., RN-B and the DON changed R3's wound vac and dressing. DON was unable to get the camera to take a picture of the wound. No wound assessment was completed or documented by RN-B or the DON. The wound vac was observed to be functioning. During observation and interview on 7/10/23 at 10:14 a.m., FM-A stated R3's machine was noted to be unplugged the previous morning (7/9/23) at 8:00 a.m. and immediately plugged it in and it started to suction. FM-A did not know how long the wound vac had been unplugged and R3 stated she was not aware the wound vac was unplugged until FM-A told her. A small amount of drainage was observed in the wound vac tubing. During an observation on 7/10/23 at 10:30 a.m., RN-A and licensed practical nurse (LPN)-A changed R3's wound dressing. R3 told RN-A that a picture was supposed to be taken of the wound with the dressing change. RN-A left the room to get the tablet computer. RN-A stated the camera on the tablet automatically measured the wound but if the camera was not functioning, they were to manually measure the wound, and document in the medical record. RN-A verified the wound vac was not functioning properly at 140 mmHg (which was not consistent with the physician order that directed 75 mmHg) RN-A then left R3's room. RN-A stated she was unsure of the battery life of the wound vac, there was an instruction book on the wound vacs but was not sure where	2 900			

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2 900	Continued From page 23 it was located and would have to check with the DON. During a follow up interview on 7/10/23 at 11:31 a.m., RN-A verified R3's wound vac was set at 140 mmHg of pressure but thought it was supposed to be set at 125 mmHg. After checking with the DON, RN-A stated the physician order was for 75 mmHg and would change the settings immediately. During an interview on 7/10/23 at 11:40 a.m., NP-A indicated a wound vac setting of 140 mmHg causes more suction and could cause increased pain. Recommendation was to start with a lower pressure setting as most people can't tolerate a setting of 140 mmHg. During an interview on 7/10/23 at 12:09 p.m., DON verified wound measurements and assessment were not done on R3 during the 7/6/23, dressing change. DON stated she was unsure of how the suction setting would have been changed on R3's wound vac and unaware that it had been unplugged. Interview on 7/11/23 at 2:12 p.m., the Administrator stated wound vacs were new to the facility within the past month and anytime there is something new like that (wound vacs) there needs to be education. The facility policy titled, Negative Pressure Wound Therapy, last revised 2/2014 directs to assess the wound prior to selecting the type, size, and thickness of dressing material. Create a barrier dressing to protect healthy skin; there should be at least a 1-inch barrier around the margins of the wound. Initiate negative pressure settings on the pump as ordered. Document in	2 900			

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2 900	Continued From page 24 the resident's medical record the wound status at the time of application of negative pressure, the number of sponge pieces used in the wound dressing, the negative pressure and time settings on the pump, and the resident's tolerance of the procedure, the date and time of the dressing application/change, the date and time negative pressure therapy was started and stopped, the names and initials of the person performing the dressing change. The immediate jeopardy that began on 6/12/23, was removed on 7/12/23, when it could be verified the facility implemented the following; -Reviewed facility policy/procedures for wound vac and wound care -Identified residents who were at risk, completed comprehensive wound assessments, reviewed/revised care plans and physician orders according to assessments. -Nursing staff were provided with Wound Vac training and demonstrated competency. 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 areas 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: Twenty-one (21) days.	2 900			