DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 3, 2019

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: 245568
Cycle Start Date: September 16, 2019

Dear Administrator:

On September 17, 2019, survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy 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 December 6, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 6, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 6, 2019.

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

NURSE AIDE TRAINING PROHIBITION

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

If you have not achieved substantial compliance by December 6, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Mary Jane Brown will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 6, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 17, 2020 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245568	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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F 000	INITIAL COMMENTS On 9/16/19 and 9/17/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H#5568018C The following complaint was found to be unsubstantied: H#5568017C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		10/24/19

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

Electronically Signed | 10/11/2019

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

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F 686	Continued From page 1 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 assess, monitor and implement pressure relieving interventions for 1 of 3 residents (R3) reviewed who were at risk for pressure ulcer development/deterioration. The facility's failure resulted in R3 sustaining harm when a stage II pressure ulcer on the thoracic spine became infected resulting in hospitalization and deterioration to a Stage IV pressure ulcer. Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) definition of Stage 2 pressure ulcer includes: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. The NPUAP definition of a Stage 4 pressure ulcer includes: Full thickness, skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some part of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar	F 686	R3 has been discharged from the facility. All residents at risk for pressure ulcers were reviewed for appropriate service to prevent and treat pressure ulcers. A new process was put into place to monitor pressure ulcers to prevent pressure ulcer deterioration. All nurses received education on the requirement to administer care as directed through the physician's orders and care plan and on the new process for monitoring pressure ulcers at a nurses meeting on 9/11/19. Random audits of the delivery of care will be conducted 2 times per week for 4 weeks and then weekly for 4 weeks by the DNS or designee to ensure appropriate care and services are implemented. Audit results will be submitted to the QAPI committee for review and recommendation. Completion Date: 10/24/19	

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F 686	Continued From page 2	F 686		

obscures the wound bed, it is an unstageable pressure ulcer. Suspected deep tissue injury are idenfied as persistent non-blanchable deep red, maroon or purple discoloration intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss.

R3's face sheet printed 9/17/19, indicated R3 had been admitted to the facility 11/14/13, with diagnoses including: chronic pain syndrome, osteoporosis (thinning bones), peripheral vascular disease (narrowing, spasms or blockage outside of the heart and brain), hypertension (high blood pressure), local infection of the skin and subcutaneous tissue, and open wound of lower back and pelvis without penetration into retroperitoneum (the space between the peritoneum and the posterior abdominal wall that contains especially the kidneys and associated structures, the pancreas, and part of the aorta and inferior vena cava).

R3's quarterly Minimum Data Set (MDS) assessment dated 7/2/19, indicated R3 had intact cognition, occasional incontinence of bowel and bladder, and required extensive assistance of one for bed mobility, transfers, dressing, toileting, personal hygiene and locomotion.

Review of R3's Care Area Assessment (CAA) dated 10/5/18, indicated R3 was at potential risk

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F 686	Continued From page 3	F 686		

for skin breakdown, although there was no risk score on the Braden assessment, and no current skin issues related to pressure. The CAA identified risk factors including: pressure requiring special mattress or seat cushion to reduce or relieve pressure, altered mental status, newly readmitted, pain and peripheral vascular disease.

Review of R3's plan of care dated 4/2/19, indicated R3 had limited physical mobility related to osteoarthritis and pain. Interventions revised on 9/3/19 included: Turn and reposition as needed; Encourage resident to lay in bed to off load buttock and spine; and Pressure reduction mat in recliner. R3 was identified as having potential/actual impairment to skin integrity related to pain initiated 5/22/14, with last revision 9/13/19. Interventions included: Education to resident/family of causative factors and measures to prevent skin injury; Monitor location, size and treatment of skin injury; Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc..to heath care provider; Provide special air bed for pressure ulcer of back; Roho wheelchair cushion (cushion that moves, preventing pressure injuries and ensuring long-term comfort and safety).

During observation and interview on 9/16/19 at 3:55 p.m., R3 was in observed on her bed. There was a specialty air bed mattress on her bed, with the head of the bed set at approximately 9 degrees. R3 stated she previously gone two days without staff changing the dressing on her back, resulting in hospitalization for a week with an infected wound. R3 also stated she had experienced increased pain in her back where the infection and pressure ulcer were located. R3 stated the pain was currently at an 8 on a scale of

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F 686	Continued From page 4	F 686		

1-10 with 10 being the worst pain. However, R3 stated staff give her pain medications to help relieve the pain and stated the specialty air mattress has helped also.

Review of a wound assessment conducted 7/17/19 by a registered nurse (RN), indicated R3 had a traumatic wound with modifications to interventions identified as friction/shear management, and to continue with current plan of treatment. Wound data documentation dated 7/17/19, was identified as an initial data collection. The wound site was identified as lower mid-vertebrae with measurements including: length 1.5 centimeters (cm) and width 0.75 cm. The wound description was identified as: Blister, red and purple color, lifting of skin, red surrounding tissue, with no drainage present. The treatment was identified as a Mepilex dressing (a special wound dressing designed to serve as an absorbent dressing for a wide range of exudate for leg and foot ulcers, pressure ulcers, surgical incisions, and traumatic wounds, such as skin tears, blisters, abrasions and secondary healing wounds), to be applied over wound.

A message sent electronically to the medical doctor (MD) 7/19/19, included a request for an order for Mepilex dressing for a blister area on mid upper spine/back area every five days, and as needed if soiled, until healed. The MD response received 7/19/19, included: "Okay for order."

Review of an RN wound assessment dated 7/25/19, indicated R3 had a traumatic wound, and interventions included for staff to continue with current plan of treatment. Wound data collected 7/25/19, indicated the wound was on the

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F 686	Continued From page 5	F 686		

vertebrae, measuring length: 1.5 cm and width: 0.75 cm. The assessment indicated a dressing was present and intact with no drainage present. Further the assessment indicated R3 denied pain related to the wound and indicated there was no presence of possible complications. The wound margins or surrounding skin were described as intact and pink. Dressing and/or treatment remained mepilex dressing.

A message sent electronically to the MD 7/29/19, included a request for an order for ice packs related to pain in R3's back. The MD response received 7/29/19, included: "Okay for cool packs as needed to affected body as needed for pain."

Review of an RN wound assessment dated 7/31/19, indicated the wound was a suspected deep tissue injury with no modifications to interventions or plan of care. There was no wound data indicated descriptions or measurements of the wound.

A nursing home physician notification form dated 8/1/19, indicated R3's wound on her back and coccyx area was enlarging, and included: "Just an FYI (for your information) for when you see her on rounds this month."

Review of an RN wound assessment dated 8/10/19, indicated R3's wound was a pressure ulcer stage 2, with no modifications to interventions. A wound data collection tool dated 8/9/19, for the vertebral site included no measurements, and indicated a dressing was present and intact with no drainage present. Further, the wound data collection tool indicated, "No presence of possible complications, increasing area of ulceration or soft tissue

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F 686	Continued From page 6	F 686		

infection." The wound margins were described as intact and pink, with no undermining or tunneling present.

Review of an RN wound assessment dated 8/15/19, indicated R3's pressure ulcer was a stage 2 with no modifications to interventions necessary for the vertebral site. The wound data collection dated 8/15/19, identified measurements of 1.6 cm length and 1.9 cm width, and indicated an intact dressing was present with no drainage present. The document indicated, there were no possible complications present, wound margins were reddened and the resident was using a Mepilex dressing.

Review of a wound data collection tool document dated 8/20/19, lacked measurements of the vertebral wound however, indicated an intact dressing was present with no drainage. "No presence of possible complications were present with wound margins intact and pink."

A message to the MD dated 8/20/19, indicated R3's wound on the spine was "becoming more errythemic (reddened). Request to change foam mepilex to a foam dressing to be changed every day and as needed." The MD response dated 8/20/19 included: "Okay for order."

Review of an RN wound assessment dated 8/23/19, indicated R3's vertebral wound was a stage 2 pressure ulcer.

Review of an RN wound assessment dated 8/30/19, indicated R3 had a stage 2 pressure ulcer on the vertebral spine. The wound data collection tool dated 8/30/19, indicated the pressure ulcer on the vertebral site measured:

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F 686	Continued From page 7	F 686		

length of 3 cm, width 3 cm and depth 0.8 cm. The wound data collection documentation further indicated a dressing was present and intact with drainage present and included: "No presence of possible complications." However, there was also documentation indicating the wound had drainage, described as moderate serosanguineous (clear liquid swirled with blood) and odor present. The documentation also indicated the dressing and treatment included a foam pad.

An electronic message to the MD 8/30/19, indicated R3 "Has an open are on her vertebrae, currently dressing with a foam dressing. Measurements are 3 cm x 3 cm x 0.8 cm with serosanguinous drainage. Please advise." The MD response recevied the same day, 8/30/19, included: "Continue with foam dressing and change every three days and as needed. Use Medihoney to open areas until healed."

R3's treatment administration record (TAR) indicated a foam dressing change was done every 3 days and as needed if soiled, and included Medihoney to open areas until healed to start 8/30/19, at 3:00 p.m. The TAR indicated the treatment was held on 8/30/19 and to see nurses' notes. A progress note dated 8/31/19 at 12:03 a.m., indicated the resident was either in bed or in her recliner. An X was recorded on the TAR for 8/31/19. On 9/1/19, the TAR documentation indicated R3 had refused twice.

A progress note documented by an RN 9/1/19 at 9:48 a.m., indicated the resident had informed the nurse she hadn't had the dressing to her back changed for the prior two evenings (8/30 and 8/31). Further the nurse documented she'd found

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F 686	Continued From page 8	F 686		

the dressing to R3's back was recorded as on hold for 8/30/19, and for 8/31/19, there was no progress note and the TAR indicated the task had not been completed. No further actions were documented.

A wound care assessment dated 9/2/19, indicated R3's wound dressing was saturated with drainage leaking around the dressing. The assessment further indicated there was a foul smell, and indicated the increased serosanguineous drainage present caused the bandage to detach from R3's skin. Further, the wound was identified as increased in size and R3 complained of pain in the wound area. The documentation indicated medihoney and a sponge bandage were applied after the wound had been cleansed with normal saline. No measurements were documented.

A progress noted dated 9/3/19 at 11:00 a.m., indicated a call had been placed to the clinic regarding R3's deteriorating wound, and an appointment had been made for 1:45 p.m.. In addition, at 11:03 a.m. a fax was sent to the primary care provider requesting a wound nurse consult for R3's deteriorating wound on her back. The progress notes indicated at 4:05 p.m., R3 was transferred from the clinic to the hospital due to the skin wound/ulcer.

The hospital History and Physical documentation dated 9/3/19, indicated R3 had an infected right lower thoracic wound and had been admitted to the hospital for treatment.

A plastics and reconstructive surgery consult note dated 9/4/19 at 5:11 p.m., indicated R3 had a posterior thoracic wound with thick persistent eschar, slough, and the wound was positive for a

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	245568	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MARY JANE BROWN	**110 SOUTH WALNUT AVENUE LUVERNE, MN 56156**

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F 686	Continued From page 9	F 686		

foul odor. The note included: "The wound measures approximately 4.3 cm x 3 cm x 2 cm and undermines at the 1-4 o'clock positions and the 9-12 o'clock positions at 4.2 cm in depth."

A nursing progress note dated 9/13/19, indicated R3 had been discharged from the hospital and readmitted to the facility.

A wound assessment completed at the nursing home 9/14/19, indicated R3 had a stage 4 pressure ulcer with the wound requiring debridement using a enzymatic topical application. The wound data collection indicated the wound measured: 3.5 cm length, by 3 cm width, and 2 cm depth. The documentation indicated a dressing was present and there was a moderate amount of serosanguinous drainage with leakage around the dressing, and the wound treatment included a dressing and Santyl ointment with dry gauze daily.

During interview with the director of nursing (DON) at 3:50 p.m. on 9/16/19, the DON stated on 9/3/19, she received a visit from a family member who was concerned the facility wasn't working urgently enough on R3's wound and requested a clinic appointment be made for evaluation of the wound. The DON stated after the family member left, an event report was located indicating the dressing changes had been omitted. The DON confirmed upon investigation, there was a two day period in which the MD orders from 8/30/19, for the Medihoney and foam dressing, were not completed. The DON stated R3 had reported to the nurse 9/1/19 that the wound dressing had not been changed in a few days, so the nurse had rescheduled the dressing change for 9/1/19 during the evening shift.

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F 686	Continued From page 10	F 686		

However, the DON stated the scheduled wound care was again not completed. The DON stated R3 was sent to the medical clinic on 9/3/19, for evaluation of the wound and was subsequently transferred from the clinic to the hospital. The DON stated she had spoken with the staff member involved who confirmed the dressing changes were not completed.

During interview with R3 on 917/19 at 8:17 a.m., R3 consented to allow the surveyor to view the dressing change to her vertebral wound. R3 was observed lying on an air therapy mattress with the head of her bed elevated to 9 degrees. A dressing was observed in place on R3's lower thoracic vertebral area. The dressing was dated 9/16/19. Registered nurse (RN)-A and licensed practical nurse (LPN)-A were present during the dressing change. After performing hand hygiene, LPN-A removed the old dressing, which was observed to have a moderate amount of serosanguineous drainage present. The wound was confirmed as a stage four pressure ulcer by both LPN-A and RN-A. RN-A completed measurements of the wound which were identified as: 4 cm length by 4 cm width with 3 cm of tunneling present. There was redness present and extending approximately 3 cm around the wound site. The wound was cleansed with sterile saline and sterile gauze, and Santyl was applied to a sterile four by four gauze pad and applied to the wound which was then covered by a second four by four gauze and anchored with a tegaderm dressing. LPN-A stated she had only seen the wound for the past two days, and stated there had been no change in the wound. RN-A stated this was her first visual inspection of the wound.

During interview on 9/17/19, at 9:25 a.m., nursing

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F 686	Continued From page 11	F 686		

assistant (NA)-A stated they reposition R3 every 2 hours or sooner upon her request. NA-A stated prior to her hospitalization, R3 was in her recliner most of the time but was still repositioned every two or three hours with toileting.

During interview on 9/17/19, at 9:32 a.m., NA-B stated they resposition R3 every hour or earlier upon R3's request. NA-B stated R3 was previously in her recliner most of the day, but was up and down frequently to the bathroom.

During interview on 9/17/19 at 10:03 a.m., RN-A stated wound cultures grew out two different bacteria from R3's vertebral wound, and stated R3 had been readmitted on an oral antibiotic, Augmentin to be continued until her next appointment with the infectious disease providers on 9/18/19.

The facility's 1/2017 policy Pressure Ulcers, included: "Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."

The facility's 3/2019 procedure, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements included: Daily monitoring when a pressure ulcer is present to include the following: An evaluation of the ulcer if no dressing is present; An evaluation of the status of the

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F 686	Continued From page 12 dressing; if present (whether it is intact and whether draining is present , if dressing is leaking or is not leaking; The status of the area surrounding the ulcer; The presence of possible complications, such as signs of increasing areas of ulceration or soft tissue infection; The pressure ulcer should be assessed/evaluated at least weekly and documented on by the RN wound assessment and if the resident is on Medicare, document daily on the wound data collection with every treatment change. In addition, the procedure indicated observations of the ulcer's characteristics should be documented by a licensed nurse and should include at least the following: - Measurements - length, width, depth, - Characteristics of the ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin etc. - Presence of Pain and - Current treatments	F 686		

Electronically Delivered

October 3, 2019

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: State Nursing Home Licensing Orders - Complaint Numbers H5568018C, H5568017C

Dear Administrator:

A complaint investigation was completed on September 17, 2019. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

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

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

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00575	A. BUILDING: _____ B. WING _____	C 09/17/2019

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GOOD SAMARITAN SOCIETY - MARY JANE BR	110 SOUTH WALNUT AVENUE LUVERNE, MN 56156

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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 9/16/19 and 9/17/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. As a result of the survey, correction orders were issued. The following complaint was found to be substantiated: H5568018C The following complaint was found to be	2 000	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	

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2 000	Continued From page 1 unsubstantied: H5568017C The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000	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 surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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. 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	

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2 000	Continued From page 2	2 000	VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 3 residents (R3) reviewed who were at risk for pressure ulcer development/deterioration. The facility's failure resulted in R3 sustaining harm when a stage II pressure ulcer on the thoracic spine became infected resulting in hospitalization and deterioration to a Stage IV pressure ulcer. Findings include: The National Pressure Ulcer Advisory Panel	2 900	R3 has been discharged from the facility. All residents at risk for pressure ulcers were reviewed for appropriate service to prevent and treat pressure ulcers. A new process was put into place to monitor pressure ulcers to prevent pressure ulcer deterioration. All nurses received education on the requirement to administer care as directed through the physician's orders and care plan and on the new process for monitoring pressure ulcers at a nurses	10/24/19

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2 900	Continued From page 3 (NPUAP) definition of Stage 2 pressure ulcer includes: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. The NPUAP definition of a Stage 4 pressure ulcer includes: Full thickness, skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some part of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the wound bed, it is an unstageable pressure ulcer. Suspected deep tissue injury are idenfied as persistent non-blanchable deep red, maroon or purple discoloration intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. R3's face sheet printed 9/17/19, indicated R3 had been admitted to the facility 11/14/13, with diagnoses including: chronic pain syndrome, osteoporosis (thinning bones), peripheral vascular disease (narrowing, spasms or blockage outside of the heart and brain), hypertension (high blood pressure), local infection of the skin and subcutaneous tissue, and open wound of lower	2 900	meeting on 9/11/19. Random audits of the delivery of care will be conducted 2 times per week for 4 weeks and then weekly for 4 weeks by the DNS or designee to ensure appropriate care and services are implemented. Audit results will be submitted to the QAPI committee for review and recommendation. Completion Date: 10/24/19	

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2 900	Continued From page 4 back and pelvis without penetration into retroperitoneum (the space between the peritoneum and the posterior abdominal wall that contains especially the kidneys and associated structures, the pancreas, and part of the aorta and inferior vena cava). R3's quarterly Minimum Data Set (MDS) assessment dated 7/2/19, indicated R3 had intact cognition, occasional incontinence of bowel and bladder, and required extensive assistance of one for bed mobility, transfers, dressing, toileting, personal hygiene and locomotion. Review of R3's Care Area Assessment (CAA) dated 10/5/18, indicated R3 was at potential risk for skin breakdown, although there was no risk score on the Braden assessment, and no current skin issues related to pressure. The CAA identified risk factors including: pressure requiring special mattress or seat cushion to reduce or relieve pressure, altered mental status, newly readmitted, pain and peripheral vascular disease. Review of R3's plan of care dated 4/2/19, indicated R3 had limited physical mobility related to osteoarthritis and pain. Interventions revised on 9/3/19 included: Turn and reposition as needed; Encourage resident to lay in bed to off load buttock and spine; and Pressure reduction mat in recliner. R3 was identified as having potential/actual impairment to skin integrity related to pain initiated 5/22/14, with last revision 9/13/19. Interventions included: Education to resident/family of causative factors and measures to prevent skin injury; Monitor location, size and treatment of skin injury; Report abnormalities, failure to heal, signs and symptoms of infection, maceration, etc..to heath care provider; Provide special air bed for pressure ulcer of back; Roho	2 900		

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2 900	Continued From page 5 wheelchair cushion (cushion that moves, preventing pressure injuries and ensuring long-term comfort and safety). During observation and interview on 9/16/19 at 3:55 p.m., R3 was in observed on her bed. There was a specialty air bed mattress on her bed, with the head of the bed set at approximately 9 degrees. R3 stated she previously gone two days without staff changing the dressing on her back, resulting in hospitalization for a week with an infected wound. R3 also stated she had experienced increased pain in her back where the infection and pressure ulcer were located. R3 stated the pain was currently at an 8 on a scale of 1-10 with 10 being the worst pain. However, R3 stated staff give her pain medications to help relieve the pain and stated the specialty air mattress has helped also. Review of a wound assessment conducted 7/17/19 by a registered nurse (RN), indicated R3 had a traumatic wound with modifications to interventions identified as friction/shear management, and to continue with current plan of treatment. Wound data documentation dated 7/17/19, was identified as an initial data collection. The wound site was identified as lower mid-vertebrae with measurements including: length 1.5 centimeters (cm) and width 0.75 cm. The wound description was identified as: Blister, red and purple color, lifting of skin, red surrounding tissue, with no drainage present. The treatment was identified as a Mepilex dressing (a special wound dressing designed to serve as an absorbent dressing for a wide range of exudate for leg and foot ulcers, pressure ulcers, surgical incisions, and traumatic wounds, such as skin tears, blisters, abrasions and secondary healing wounds), to be applied over wound.	2 900		

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2 900	Continued From page 6 A message sent electronically to the medical doctor (MD) 7/19/19, included a request for an order for Mepilex dressing for a blister area on mid upper spine/back area every five days, and as needed if soiled, until healed. The MD response received 7/19/19, included: "Okay for order." Review of an RN wound assessment dated 7/25/19, indicated R3 had a traumatic wound, and interventions included for staff to continue with current plan of treatment. Wound data collected 7/25/19, indicated the wound was on the vertebrae, measuring length: 1.5 cm and width: 0.75 cm. The assessment indicated a dressing was present and intact with no drainage present. Further the assessment indicated R3 denied pain related to the wound and indicated there was no presence of possible complications. The wound margins or surrounding skin were described as intact and pink. Dressing and/or treatment remained mepilex dressing. A message sent electronically to the MD 7/29/19, included a request for an order for ice packs related to pain in R3's back. The MD response received 7/29/19, included: "Okay for cool packs as needed to affected body as needed for pain." Review of an RN wound assessment dated 7/31/19, indicated the wound was a suspected deep tissue injury with no modifications to interventions or plan of care. There was no wound data indicated descriptions or measurements of the wound. A nursing home physician notification form dated 8/1/19, indicated R3's wound on her back and coccyx area was enlarging, and included: "Just	2 900		

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	00575	A. BUILDING: _____ B. WING _____	C 09/17/2019

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2 900	Continued From page 7	2 900		

an FYI (for your information) for when you see her on rounds this month."

Review of an RN wound assessment dated 8/10/19, indicated R3's wound was a pressure ulcer stage 2, with no modifications to interventions. A wound data collection tool dated 8/9/19, for the vertebral site included no measurements, and indicated a dressing was present and intact with no drainage present. Further, the wound data collection tool indicated, "No presence of possible complications, increasing area of ulceration or soft tissue infection." The wound margins were described as intact and pink, with no undermining or tunneling present.

Review of an RN wound assessment dated 8/15/19, indicated R3's pressure ulcer was a stage 2 with no modifications to interventions necessary for the vertebral site. The wound data collection dated 8/15/19, identified measurements of 1.6 cm length and 1.9 cm width, and indicated an intact dressing was present with no drainage present. The document indicated, there were no possible complications present, wound margins were reddened and the resident was using a Mepilex dressing.

Review of a wound data collection tool document dated 8/20/19, lacked measurements of the vertebral wound however, indicated an intact dressing was present with no drainage. "No presence of possible complications were present with wound margins intact and pink."

A message to the MD dated 8/20/19, indicated R3's wound on the spine was "becoming more errythemic (reddened). Request to change foam mepilex to a foam dressing to be changed every

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2 900	Continued From page 8	2 900		

day and as needed." The MD response dated 8/20/19 included: "Okay for order."

Review of an RN wound assessment dated 8/23/19, indicated R3's vertebral wound was a stage 2 pressure ulcer.

Review of an RN wound assessment dated 8/30/19, indicated R3 had a stage 2 pressure ulcer on the vertebral spine. The wound data collection tool dated 8/30/19, indicated the pressure ulcer on the vertebral site measured: length of 3 cm, width 3 cm and depth 0.8 cm. The wound data collection documentation further indicated a dressing was present and intact with drainage present and included: "No presence of possible complications." However, there was also documentation indicating the wound had drainage, described as moderate serosanguineous (clear liquid swirled with blood) and odor present. The documentation also indicated the dressing and treatment included a foam pad.

An electronic message to the MD 8/30/19, indicated R3 "Has an open are on her vertebrae, currently dressing with a foam dressing. Measurements are 3 cm x 3 cm x 0.8 cm with serosanguinous drainage. Please advise." The MD response recevied the same day, 8/30/19, included: "Continue with foam dressing and change every three days and as needed. Use Medihoney to open areas until healed."

R3's treatment administration record (TAR) indicated a foam dressing change was done every 3 days and as needed if soiled, and included Medihoney to open areas until healed to start 8/30/19, at 3:00 p.m. The TAR indicated the treatment was held on 8/30/19 and to see nurses'

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2 900	Continued From page 9	2 900		

notes. A progress note dated 8/31/19 at 12:03 a.m., indicated the resident was either in bed or in her recliner. An X was recorded on the TAR for 8/31/19. On 9/1/19, the TAR documentation indicated R3 had refused twice.

A progress note documented by an RN 9/1/19 at 9:48 a.m., indicated the resident had informed the nurse she hadn't had the dressing to her back changed for the prior two evenings (8/30 and 8/31). Further the nurse documented she'd found the dressing to R3's back was recorded as on hold for 8/30/19, and for 8/31/19, there was no progress note and the TAR indicated the task had not been completed. No further actions were documented.

A wound care assessment dated 9/2/19, indicated R3's wound dressing was saturated with drainage leaking around the dressing. The assessment further indicated there was a foul smell, and indicated the increased serosanguineous drainage present caused the bandage to detach from R3's skin. Further, the wound was identified as increased in size and R3 complained of pain in the wound area. The documentation indicated medihoney and a sponge bandage were applied after the wound had been cleansed with normal saline. No measurements were documented.

A progress noted dated 9/3/19 at 11:00 a.m., indicated a call had been placed to the clinic regarding R3's deteriorating wound, and an appointment had been made for 1:45 p.m.. In addition, at 11:03 a.m. a fax was sent to the primary care provider requesting a wound nurse consult for R3's deteriorating wound on her back. The progress notes indicated at 4:05 p.m., R3 was transferred from the clinic to the hospital due to the skin wound/ulcer.

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2 900	Continued From page 10 The hospital History and Physical documentation dated 9/3/19, indicated R3 had an infected right lower thoracic wound and had been admitted to the hospital for treatment. A plastics and reconstructive surgery consult note dated 9/4/19 at 5:11 p.m., indicated R3 had a posterior thoracic wound with thick persistent eschar, slough, and the wound was positive for a foul odor. The note included: "The wound measures approximately 4.3 cm x 3 cm x 2 cm and undermines at the 1-4 o'clock positions and the 9-12 o'clock positions at 4.2 cm in depth." A nursing progress note dated 9/13/19, indicated R3 had been discharged from the hospital and readmitted to the facility. A wound assessment completed at the nursing home 9/14/19, indicated R3 had a stage 4 pressure ulcer with the wound requiring debridement using a enzymatic topical application. The wound data collection indicated the wound measured: 3.5 cm length, by 3 cm width, and 2 cm depth. The documentation indicated a dressing was present and there was a moderate amount of serosanguinous drainage with leakage around the dressing, and the wound treatment included a dressing and Santyl ointment with dry gauze daily. During interview with the director of nursing (DON) at 3:50 p.m. on 9/16/19, the DON stated on 9/3/19, she received a visit from a family member who was concerned the facility wasn't working urgently enough on R3's wound and requested a clinic appointment be made for evaluation of the wound. The DON stated after the family member left, an event report was	2 900		

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2 900	Continued From page 11 located indicating the dressing changes had been omitted. The DON confirmed upon investigation, there was a two day period in which the MD orders from 8/30/19, for the Medihoney and foam dressing, were not completed. The DON stated R3 had reported to the nurse 9/1/19 that the wound dressing had not been changed in a few days, so the nurse had rescheduled the dressing change for 9/1/19 during the evening shift. However, the DON stated the scheduled wound care was again not completed. The DON stated R3 was sent to the medical clinic on 9/3/19, for evaluation of the wound and was subsequently transferred from the clinic to the hospital. The DON stated she had spoken with the staff member involved who confirmed the dressing changes were not completed. During interview with R3 on 917/19 at 8:17 a.m., R3 consented to allow the surveyor to view the dressing change to her vertebral wound. R3 was observed lying on an air therapy mattress with the head of her bed elevated to 9 degrees. A dressing was observed in place on R3's lower thoracic vertebral area. The dressing was dated 9/16/19. Registered nurse (RN)-A and licensed practical nurse (LPN)-A were present during the dressing change. After performing hand hygiene, LPN-A removed the old dressing, which was observed to have a moderate amount of serosanguineous drainage present. The wound was confirmed as a stage four pressure ulcer by both LPN-A and RN-A. RN-A completed measurements of the wound which were identified as: 4 cm length by 4 cm width with 3 cm of tunneling present. There was redness present and extending approximately 3 cm around the wound site. The wound was cleansed with sterile saline and sterile gauze, and Santyl was applied to a sterile four by four gauze pad and applied to	2 900		

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2 900	Continued From page 12 the wound which was then covered by a second four by four gauze and anchored with a tegaderm dressing. LPN-A stated she had only seen the wound for the past two days, and stated there had been no change in the wound. RN-A stated this was her first visual inspection of the wound. During interview on 9/17/19, at 9:25 a.m., nursing assistant (NA)-A stated they reposition R3 every 2 hours or sooner upon her request. NA-A stated prior to her hospitalization, R3 was in her recliner most of the time but was still repositioned every two or three hours with toileting. During interview on 9/17/19, at 9:32 a.m., NA-B stated they resposition R3 every hour or earlier upon R3's request. NA-B stated R3 was previously in her recliner most of the day, but was up and down frequently to the bathroom. During interview on 9/17/19 at 10:03 a.m., RN-A stated wound cultures grew out two different bacteria from R3's vertebral wound, and stated R3 had been readmitted on an oral antibiotic, Augmentin to be continued until her next appointment with the infectious disease providers on 9/18/19. The facility's 1/2017 policy Pressure Ulcers, included: "Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that resident entering the location without pressure ulcers does not develop a pressure ulcer unless the individual's clinical condition demonstrates that this was unavoidable. A resident who has a pressure ulcer will receive the necessary treatment and services to promote healing, prevent infection and prevent new pressure ulcers from developing."	2 900		

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2 900	Continued From page 13 The facility's 3/2019 procedure, Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements included: Daily monitoring when a pressure ulcer is present to include the following: An evaluation of the ulcer if no dressing is present; An evaluation of the status of the dressing; if present (whether it is intact and whether draining is present , if dressing is leaking or is not leaking; The status of the area surrounding the ulcer; The presence of possible complications, such as signs of increasing areas of ulceration or soft tissue infection; The pressure ulcer should be assessed/evaluated at least weekly and documented on by the RN wound assessment and if the resident is on Medicare, document daily on the wound data collection with every treatment change. In addition, the procedure indicated observations of the ulcer's characteristics should be documented by a licensed nurse and should include at least the following: - Measurements - length, width, depth, - Characteristics of the ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin etc. - Presence of Pain and - Current treatments SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for	2 900		

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2 900	Continued From page 14 pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		