Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL291859312M
Compliance #: HL291857093C

Date Concluded: July 10, 2024

Name, Address, and County of Licensee Investigated:
The Legacy of St. Michael
4400 Lange Avenue Northeast
St. Michael, MN 55376
Wright County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the facility staff failed to provide wound care and initiate interventions timely when the resident obtained a pressure wound.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to initiate wound care and monitor the wound routinely for nearly one month. The resident first developed a new pressure ulcer at a stage 1 (unopened). After a month without monitoring or providing wound care, the wound deteriorated to a stage 3 (full thickness tissue loss) when staff notified the primary care provider (PCP) for wound care orders. The resident's wound had a foul odor and continued to deteriorate when home health skilled nursing services began.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker. The

investigation included review of the resident records, home health records, hospital records, wound care clinic records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed other resident's wound dressings while on site.

The resident resided in an assisted living facility memory care unit. The resident's diagnoses included multiple sclerosis and cognitive impairment. The resident's service plan included assistance with toileting, transfers, and repositioning. The resident's assessment indicated the resident had poor short-term memory and required a full body mechanical lift for transfers. The resident's assessment prior to the wound indicated her skin condition was normal and she had no skin issues.

The resident's progress note indicated unlicensed personnel (ULP) reported to facility licensed practical nurse (LPN) 1 there was a reddened hard area [stage 1] on the resident's buttock. LPN 1 instructed the evening ULP to notify her when the resident was laying down, however the evening ULP and lead ULP reported there was no area and LPN 1 did not observe the area nor document she reported to a registered nurse (RN) to assess the area.

Two days later, the resident's progress note indicated the RN noted an open area [stage 2 (open, partial tissue loss)] to the resident's right buttock measuring 2 centimeters (cm) x 2 cm with a hard spot under the tissue near the opening. The RN cleansed the area, covered it with a medical dressing and left a note in a paper binder for the resident's provider on the next rounds. Four days later, LPN 1 documented she updated the resident's PCP of an open area to the resident's left buttock (not right) and did not receive any new orders.

Review of the resident's PCP orders, notes and triage calls did not include communication from LPN 1 nor the RN. The RN failed to add wound care nursing orders to the resident's service delivery record and failed to initiate weekly wound care monitoring per the facility's policy. There was no record of wound care provided to the resident for 19 days.

The resident's progress notes indicated 19 days later a ULP notified LPN 2 the resident had an open area on her right buttock. LPN 2 documented the wound measured 2 cm x 2 cm with 4 millimeter (mm) depth. The wound bed had white/yellow slough (macerated tissue) with dark/black (dead) tissue. LPN 2 noted a slight foul odor. LPN 2 performed wound care by cleansing the area, applied skin prep and covered with a foam dressing. LPN 2 instructed ULP to reposition the resident every two hours. LPN 2 sent a note with wound order request to the resident's PCP through the medical provider portal. That same day, LPN 2 received orders to cleanse the wound with wound cleanser, pat it dry, apply skin prep on the surrounding area, cover with a foam dressing every three days and as needed. Also, a referral for home health skilled nursing for wound care was received.

Three days later, the resident's progress notes indicated the RN changed the resident's dressing due to soiling. The RN noted the wound bed had yellow/white slough with moderate amount of

drainage. The resident's service delivery record had the wound care orders received by LPN 2 and the RN's documentation of providing the wound care that day, was the only documented wound care provided for the month by the facility on the service delivery record.

The next day, the assistant director of nursing (ADON) completed a nursing assessment. The assessment indicated the resident required turning and repositioning. The assessment indicated the resident's pressure ulcer to her buttocks was stage 3 (full thickness tissue loss). Weekly skin assessments were initiated the same day as the nursing assessment. The DON completed the initial weekly skin assessment and inaccurately documented the wound first started upon LPN 2's observation (four days prior), when it had originated nearly a month prior. The skin assessment indicated the resident's wound had moderate drainage with odor present. The assessment indicated both the facility and skilled nursing managed the wound care.

Review of the resident's home health skilled nursing visit notes and triage call notes indicated the home health skilled nursing completed intake of services with the resident five days after the RN completed the first wound care after receiving the PCP wound care orders. The records indicated the first skilled nursing wound care was provided nine days after the RN's last wound care provided.

The facility failed to provide two required dressing changes per the PCP's orders to change the dressing every three days.

Review of the resident's home health skilled nursing visit notes, physician orders and wound care clinic notes indicated the resident's wound continued to deteriorate and required several changes in wound care orders. The PCP face to face appointment with the resident occurred 13 days after LPN 2 requested and received wound care orders. The resident first went to the wound care clinic 30 days after home health initiated wound services for further intervention. The resident received three consecutive wound debridement's at the wound clinic weekly appointments before the provider requested surgical consult. The resident's condition deteriorated and required hospitalization for wound care and surgical intervention. After hospitalization, the resident was unable to return to the facility due to the need for higher acuity of care related to her wound care and wound V.A.C therapy (a negative pressure wound dressing applied to promote healing). The resident has resided at a skilled nursing facility since discharge from the hospital.

During an interview, the DON stated staff should notify a provider of a new wound by calling them, not by a note left in a binder. The DON stated she started assessing the wound weekly in collaboration with home health nurse once they were involved. The DON stated staff should document wound prevention interventions on the service delivery record.

During an interview, the RN stated staff used a binder to leave written communications to the PCP, including notifications of new wounds. The RN stated the provider would come to the facility twice weekly. The RN stated until the provider responded, she did not know what she

should do for the wound. The RN stated she did not know how to reposition the resident when she was in her wheelchair.

During an interview, LPN 1 stated she would leave a note in the binder for the provider only if she knew they were coming in the next day. LPN 1 stated the other nurses look on the communication board or check their email for notification of new wounds and what wound care staff completed. LPN 1 stated it was not typical to leave a note for a provider when there is a new open wound. LPN 1 stated it was not acceptable for staff to notify a provider a week after a new wound has developed.

During an interview, a family member stated he did not feel comfortable returning the resident to the facility after her hospital stay due to negligent care. At the time of the interview, the family member stated the resident continued to require wound care.

The resident was not able to complete an interview.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, unable to complete.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The facility requested wound care orders and assisted with arrangement of wound care clinic appointments.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Wright County Attorney
St. Michael City Attorney
St. Michael Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29185	A. BUILDING: _____ B. WING _____	C 04/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST MICHAEL	4400 LANGE AVENUE NE SAINT MICHAEL, MN 55376

(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
0 000	Initial Comments ******ATTENTION***** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL291857093C/#HL291859312M On April 12, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 95 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for ##HL291857093C/#HL291859312M, tag identification 1620, 1640, 1960, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to have a registered nurse (RN) assess a change of condition in a residents skin, and provide ongoing wound monitoring for 1 of 1 residents reviewed (R1) with a pressure ulcer. R1 developed a new pressure ulcer at a stage one (not opened). The licensee failed to assess and provide routine monitoring of the ulcer for nearly one month resulting in the ulcer progressing to a stage three (full thickness tissue loss). This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01620		

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01620	Continued From page 2 not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee policy titled "Wound Care and Pressure Injury," dated August 2023, indicated a RN is responsible for assessing skin when alerted to skin changes by staff and is to notify the physician within twenty-four hours to obtain orders for wound treatment. The policy indicated the RN is to assess the wound weekly. The document indicated a need for reassessment of the pressure injury, and the residents overall clinical condition, for pressure areas that fail to show progress towards healing within two to four weeks. R1's diagnosis included multiple sclerosis and cognitive impairment. R1's service plan dated October 12, 2023, indicated R1 received assistance with toileting, transfers, bathing, turning, and repositioning twice daily. R1's 90-day nursing assessment dated June 12, 2023, indicated R1's skin condition was normal and there were no skin issues. R1's nurses notes dated August 9, 2023, at 6:24 p.m., written by licensed practical nurse (LPN)-F, indicated unlicensed personnel (ULP) reported a hard, reddenned area on R1's buttock. LPN-F instructed the evening ULP to notify her when R1 was laying down. LPN-F's noted indicated the ULP and lead [ULP] reported there was no	01620		

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01620	Continued From page 3 hardened area on R1 as reported. There was no documentation a registered nurse (RN) assessed the area. R1's nurses notes dated August 11, 2023, at 11:43 a.m., written by RN-E, indicated R1 had a reddened area [stage 1] on her right buttock measuring 2 centimeters (cm) x 2 cm. There was a hard spot under the skin next to the area. RN-E cleansed the area and placed a medical dressing over it. RN-E placed an update sheet in the communication binder for the medical provider. The nurse note did not indicate evidence of interventions initiated. R1's record lacked documentation R1's medical provider was notified and obtained wound care orders. R1's service delivery record dated August 2023, failed to include nursing orders to cleanse the wound and place a dressing over it. R1's nurses notes dated August 15, 2023, at 2:40 p.m., indicated LPN-F notified R1's provider of the open area on the left buttock. LPN-F documented the provider noted the message and no new orders received from the provider. R1's record lacked weekly skin assessments by an RN on R1's buttock pressure ulcer due August 18, 2023, August 25, 2023 and September 1, 2023. R1's nurses notes dated September 3, 2023, at 9:46 a.m., written by LPN-G, indicated ULP reported R1 had an open area on her right buttock. LPN-G documented she performed wound care and instructed the staff to reposition R1 every two hours. The wound measured 2 cm x	01620		

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01620	Continued From page 4 2 cm with 4 millimeter (mm) depth. The wound bed had white/yellow slough with dark/black tissue. LPN-G noted a slight foul odor. LPN-G cleansed the area, applied skin prep and covered with a mepilex (foam) dressing. LPN-G sent a note with wound order request to the medical provider portal. At 11:39 a.m., LPN-G received orders to cleanse the wound with wound cleanser, pat it dry, apply skin prep on surrounding area and cover with a mepilex dressing every three days and as needed and skilled nursing for wound care. R1's nurses notes dated September 6, 2023, written by RN-E, indicated she changed R1's dressing due to soiling from a bowel movement. RN-E wrote the wound bed had yellow/white slough with moderate drainage. No odor noted. RN-E did not document she measured the wound. R1's nursing assessment dated September 7, 2023, indicated R1 required assistance with turning and repositioning and required the use of a full body mechanical lift for transfers. The assessment indicated R1's had a stage three (full thickness tissue loss) pressure ulcer to her buttocks with wound care provided three to four times weekly. In addition, R1 had arterial ulcers, but did not indicate the location. R1's Weekly Alteration in Skin Integrity assessment dated September 7, 2023, incorrectly indicated the date of wound onset was September 3, 2023. The same document indicated moderate exudate with odor present. R1's home health agency notes indicated home health skilled nursing for wound care initiated on September 15, 2023.	01620		

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01620	Continued From page 5 R1's wound clinic care note dated April 17, 2024, labeled the wound as a non-healing, full thickness wound. During an interview on April 17, 2024, at 1:00 p.m., family member (F)-A stated R1 needed to relocate her residence to receive appropriate care, and the wound has remained present. F-A stated R1 continued to have weekly appointments at the wound care clinic. During an interview on April 19, 2024, at 1:00 p.m., RN-C stated a nurse should assess a new wound when staff alert them of a new wound. During an interview on April 23, 2023, at 11: 32 a.m., RN-E stated if staff alert her of a new wound, she provides general wound care and waits to get orders from the provider. RN-E was not sure what else she could do while waiting for the provider to give orders. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 6 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to revise the service plan to include turn and repositioning services, and wound care services as required for 1 of 1 residents reviewed (R1). As a result, services to turn and reposition R1 were not documented. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The International Affairs and Best Practice Guidelines guidebook titled "Assessment and Management of Pressure Injuries for the Interprofessional Team" dated May 2016, third edition, page twelve, indicated standard practice recommendations of repositioning a person at	01640		

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01640	Continued From page 7 risk for or with a pressure injury present at regular intervals such as every two to four hours based on person-centered concerns. Additionally, a person should be weight-shifted every fifteen minutes while sitting. R1's diagnosis included multiple sclerosis and cognitive impairment. R1's service delivery record for August 1 to August 11, 2023, indicated R1 received scheduled repositioning, toileting, transfer, escort and meal assist schedule was as follows: Toileting at 1:30 a.m. with repositioning Toileting at 5:30 a.m. with repositioning Toileting at 7:30 a.m. with a transfer with mechanical lift Escort at 8:30 a.m. Meal assist at 9:00 a.m. Toileting at 11:30 a.m. with a transfer with mechanical lift Escort at 12:00 p.m. with meal assist Transfer with mechanical lift at 12:30 p.m. Transfer with mechanical lift at 2:00 p.m. Transfer with mechanical lift at 4:00 p.m. Escort at 4:30 p.m. Meal assist at 5:00 p.m. Toileting at 5:30 p.m. with a transfer with mechanical lift Toileting at 7:30 p.m. with a transfer with mechanical lift Toileting at 9:30 p.m. R1's nurses notes dated August 11, 2023, at 11:43 a.m. indicated a reddened area on the resident right buttock by registered nurse (RN)-E. RN-E cleansed the area and placed a medical dressing over it. RN-E placed an update sheet in the communication binder for the provider. The note did not indicate evidence of interventions	01640		

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01640	Continued From page 8 initiated. R1's nurses notes dated September 3, 2023, at 9:46 a.m., indicated R1 had an open area on her right buttock. Licensed practical nurse (LPN)-G documented she performed wound care and instructed the staff to reposition R1 every two hours. At 11:39 a.m., LPN-G received orders to cleanse the wound with wound cleanser, pat it dry, apply skin prep on surrounding area and cover with a mepilex dressing every three days and as needed. R1's nursing assessment dated September 7, 2023, indicated R1 required assistance with turning and repositioning and required the use of a full body mechanical lift for transfers. R1's Weekly Alteration in Skin Integrity assessment dated September 7, 2023, completed by director of nursing (DON)-C, indicated preventative measures included turning and repositioning every two hours. R1's service delivery records dated August 2023, September 2023, October 2023, failed to include services for staff to turn and reposition R1 every two hours. R1's service delivery records remained unchanged from the scheduled repositioning, toileting, transfer, escort and meal assist prior to August 11, 2023. R1's service agreement dated October 12, 2023, did not included wound care services and assistance with turning and repositioning every two hours. The agreement indicated R1 received turning and repositioning services at 01:30 a.m., and 05:30 a.m. During an interview on April 19, 2024, at 1:00	01640		

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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
01640	Continued From page 9 p.m., RN-C stated a nurse assesses a wound weekly. RN-C stated when the nurse goes to look at a new wound, the nurse would take a full assessment at that time, notify the provider, and initiate interventions such as position changes. RN-C stated the staff should sign off in the service delivery record wound care provided. RN-C stated R1 was repositioned every two hours and the turning and repositioning should be on the service delivery record. RN-C stated she may have neglected to put directive for every two-hour repositioning on the service delivery record. During an interview on April 29, 2024, at 9:59 a.m., LPN-F stated new services should be on the service delivery record. The licensee-provided policy titled Wound Care and Pressure Injury, dated August 2023 indicated the nurse will add wound care orders to the residents individualize plan of care and educate staff on cares to provide. The same policy indicated the individualized service plan will reflect approaches to stabilize, reduce or remove the individual risk factors for pressure injury development and/or promote healing of existing pressure ulcers. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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	29185	A. BUILDING: _____ B. WING _____	C 04/12/2024

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01960	Continued From page 10 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement and document nursing orders for a new pressure ulcer and failed to provide wound care as prescribed once ordered by the medical provider for 1 of 1 residents reviewed (R1). R1 acquired a pressure ulcer and the licensee failed to implement nursing orders to manage the wound for 23 days until a medical provider wound order was received. The licensee provided wound care twice per documentation and failed to provide wound care as ordered for nine days until home health skilled nursing services started. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnosis included multiple sclerosis and cognitive impairment. R1's service plan dated October 12, 2023, indicates R1 receives assistance with toileting, transfers, bathing,	01960		

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01960	Continued From page 11 turning, and repositioning twice daily. R1's 90-day nursing assessment dated June 12, 2023, indicated R1's skin condition was normal and there were no skin issues. R1's nurses notes dated August 11, 2023, at 11:43 a.m., written by registered nurse (RN)-E, indicated R1 had a reddened area [stage 1] on her right buttock measuring 2 centimeters (cm) x 2 cm. There was a hard spot under the skin next to the area. RN-E cleansed the area and placed a medical dressing over it. RN-E placed an update sheet in the communication binder for the medical provider. The nurse note did not indicate evidence of interventions initiated. R1's record lacked documentation R1's medical provider was notified and obtained wound care orders. R1's service delivery record dated August 2023, failed to include nursing orders to cleanse the wound and place a dressing over it initiated by RN-E. R1's nurses notes dated September 3, 2023, at 9:46 a.m., written by licensed practical nurse (LPN)-G, indicated unlicensed personnel (ULP) reported R1 had an open area on her right buttock. LPN-G documented she performed wound care and instructed the staff to reposition R1 every two hours. The wound measured 2 cm x 2 cm with 4 millimeter (mm) depth. The wound bed had white/yellow slough with dark/black tissue. LPN-G noted a slight foul odor. LPN-G cleansed the area, applied skin prep and covered with a mepilex (foam) dressing. LPN-G sent a note with wound order request to the medical provider portal. At 11:39 a.m., LPN-G received	01960		

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01960	Continued From page 12 orders to cleanse the wound with wound cleanser, pat it dry, apply skin prep on surrounding area and cover with a mepilex dressing every three days and as needed and skilled nursing for wound care. R1's provider portal note dated September 3, 2023, indicated a nurse practitioner was notified of the wound and ordered to continue current wound care (change daily if draining) and skilled nursing home health services. R1's nurses notes dated September 6, 2023, written by RN-E, indicated she changed R1's dressing due to soiling from a bowel movement. RN-E wrote the wound bed had yellow/white slough with moderate drainage. No odor noted. RN-E did not document she measured the wound. R1's service delivery record dated September 2023, indicated RN-E's wound care was documented on September 6, 2023, with no other entries for the month and no as needed dressing changes provided. R1's Weekly Alteration in Skin Integrity assessment started September 7, 2023. The weekly skin assessment indicated the facility staff and home health skilled nursing provide wound care. R1's provider portal note dated September 11, 2023, indicated intake with the home health agency was completed. R1's provider orders dated September 14, 2023, indicated the provider completed a face-to-face appointment with R1 for her wound.	01960		

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01960	Continued From page 13 R1's home health agency notes indicated home health skilled nursing for wound care initiated and was provided on September 15, 2023 by the home health RN. R1's provider orders dated September 19, 2023, included a note from the licensee to the provider. The note indicated R1's wound was deteriorating, skilled nursing provides wound care Monday, Wednesday and Friday with no change to orders. The wound has a foul odor and requested different orders. The note dictated "we are very concerned about this wound." The medical provider ordered new wound care orders to cleanse the wound, pack wound with wound ribbon, cover with a foam dressing, change every other day and as needed for 14 days. Then resume usual skilled nursing visits plus three as needed visits for wound care. The licensee failed to transcribed the new orders to R1's September 2023 service delivery record (where previous wound care order was transcribed). R1's September 2023 service delivery record included an outdated order indicating to cleanse the wound, apply skin prep around the area, cover with a foam dressing, change every three days and as needed. R1's pharmacy prescription dated September 29, 2023, indicated an order for Santyl ointment (topical debridement) to be used with wound care. The licensee failed to transcribed the updated order of using Santyl ointment to R1's September 2023 service delivery record. R1's provider orders dated October 11, 2023, included a change to R1's wound orders. The	01960		

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01960	Continued From page 14 new order indicated to discontinue all previous orders, every other day remove dressings, cleanse with warm soap and water. Rinse with normal saline. Apply gauze soaked with vashe and leave sit for 10 minutes. Apply iodsorb gel (anti-infective) to ulcer base and fill in the void loosely with packing, cover with a foam dressing. The licensee failed to transcribed the new orders to R1's October 2023 service delivery record. R1's October 2023 service delivery record included an outdated order indicating to cleanse the wound, apply skin prep around the area, cover with a foam dressing, change every three days and as needed. During an interview on April 19, 2024, at 1:00 p.m., RN-C stated new services should be in the service delivery record, and she may have neglected to put it in the service delivery record. The licensee policy titled "Wound Care and Pressure Injury," dated August 2023, indicated a RN is responsible for assessing skin when alerted to skin changes by staff and is to notify the physician within twenty-four hours to obtain orders for wound treatment. The policy indicated a nurse will implement wound/pressure injury care once the orders have been obtained by adding them to the resident's care plan and educate staff on cares to be provided. The service plan will reflect approaches to stabilize, reduce or remove the risk factors for pressure injury and/or promote healing of existing pressure ulcers. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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02360	Continued From page 15	02360		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	