Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306193784M
Compliance #: HL306196287C

Date Concluded: February 22, 2023

Name, Address, and County of Licensee Investigated:
Plainview Estates
2507 Fairview Ave
Cloquet, MN 55720
Carlton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, RN - Special Investigator

Finding: Inconclusive

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 and alleged perpetrator (AP) neglected a resident when they failed to provide incontinence care and repositioning, as a result, the resident's pressure ulcers worsened.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident had a sacral pressure ulcer that progressively worsened, the resident had multiple comorbidities and was receiving end-of-life care. The residents medical record lacked documentation regarding incontinent care or repositioning was provided to the resident. However, staff and family indicated repositioning and incontinence care were provided for the resident according to the residents individualized plan of care. It could not be determined if the residents pressure ulcers worsened due to lack of staff assistance with incontinence care and repositioning.

The investigator conducted interviews with facility staff members, including administrative, nursing, and unlicensed staff. The investigation included review of the resident's care plan, service agreement, progress notes, medication/treatment administration records (MAR/TAR), employee records, hospice medical records, after visit provider summaries, provider notes and orders, and facility policies and procedures. In addition, the investigator observed other residents in the facility.

The resident resided in an assisted living facility with diagnoses including vascular dementia, and progressive supranuclear ophthalmoplegia (a rare brain disorder causing neurologic problems with movement). The resident was cognitively impaired and received hospice end of life services.

The resident's Hospice admission assessment and care plan indicated the resident had redness on his coccyx. The assessment and care plan indicated the resident would be repositioned every two hours while in bed or chair.

The resident's facility assessment, completed when the resident was admitted to hospice, indicated the resident had fragile skin, and had a stage one pressure ulcer on his coccyx with blanchable redness. The assessment indicated the resident required assistance from staff with incontinence care and repositioning every two hours.

The residents care plan failed to instruct staff to reposition the resident every two hours according to the facility assessment. The residents service agreement failed to indicate what services were provided to the resident. The residents medical record contained no documentation regarding how often the resident was assisted with incontinence care and positioning.

About two weeks after the resident was admitted to hospice, a physician after-visit summary (AVS) indicated the resident had a "stable" stage 2 coccyx sacral (the tailbone area) pressure ulcer.

Ten days later a hospice provider order indicated the residents pressure ulcer was a stage 3.

A facility nurses note indicated the resident was utilizing an air mattress, and staff were encouraged to reposition the resident every two hours and as needed.

About two months after admission to hospice, a provider AVS indicated the resident was seen for wound care follow up and the resident's coccyx pressure ulcer was now a stage 4, with visible bone and muscle present. The pressure ulcer was unstable, and indicated the wound appeared to be a Kennedy ulcer (an un-preventable ulcer that develops rapidly, within hours, preceding death).

One week later a provider AVS note indicated the resident was seen for a follow up to assess his wound and pain. The exam indicated the resident had a stage 4 pressure ulcer with a yellow gray wound bed and visible bone and muscle. The note indicated the resident's prognosis was very poor and he was completely bed bound.

When interviewed facility staff stated they provided repositioning every two hours and incontinence care for the resident. The staff stated they did not document services provided to the resident including repositioning and incontinence care, but verbally reported the last time the resident was repositioned during a change of shift verbal report. Staff stated they had no concerns about co-workers not providing incontinence care or repositioning for the resident.

When interviewed the resident's family member expressed the resident was well cared for in the facility and had no concerns regarding his care.

When interviewed the AP stated the resident was repositioned and assisted with incontinence care at least every two hours.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken

Action taken by the Minnesota Department of Health:
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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities Carlton County Attorney
Cloquet City Attorney
Cloquet Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30619	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLAINVIEW ESTATES	2507 FAIRVIEW AVENUE CLOQUET, MN 55720

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL306193784M/ # HL306196287C On January 10, 2023, 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 four residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL306193784M, and HL306196287C, tag identification 0730 and 2310.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 1 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 2 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records had the required content following a change in condition, admission to hospice, and after developing pressure ulcers for one of one residents (R1) reviewed. 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). Findings include: R1 was admitted to the facility on July 27, 2021, with diagnoses including hypertension, cerebral arthrosclerosis, and vascular dementia. R1's hospice admission assessment and care plan dated September 19, 2022, indicated R1 had no open areas. The assessment and care plan indicated R1's skin was pale in appearance with redness on his coccyx area, and staff were to apply barrier cream for protection and reposition R1 every two hours. R1's "Summary - Annual Assessment" dated	0 730		

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0 730	Continued From page 3 September 20, 2022, completed at the time R1 was admitted to hospice, indicated R1 had fragile skin with a stage 1 pressure ulcer, with blanchable redness noted. The assessment indicated offloading, and repositioning would be done every two hours. The assessment indicated R1 was totally dependent on staff for ADL's including dressing, toileting, and incontinence care. R1 needed staff assistance to reposition in bed every two hours, and required a EZ stand mechanical lift for transfers, and was dependent on staff for mobility using a wheelchair. R1's admission Vulnerability Assessment failed to indicate R1 was dependent on staff for ADL's. The assessment indicated it was reviewed on September 20, 2022, when R1 was admitted to hospice but was not updated. R1's undated service agreement failed to include services the facility would provide. R1's undated care plan failed to indicate R1 required assistance with ADL's, including toileting, mobility, and repositioning every two hours following a change of condition when the resident was admitted to hospice for end-of-life care, and after developing pressure ulcers. The care plan failed to include wound monitoring of R1's pressure ulcer, wound care, and interventions implemented to prevent new or worsening pressure ulcers. R1's medication and treatment administration record (MAR/TAR) for September 2022, lacked documentation for wound monitoring, wound care, or repositioning being provided even though it was identified R1 had a pressure ulcer on September 19, 2022, when hospice ordered R1 to be repositioned every two hours.	0 730		

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0 730	Continued From page 4 A provider order dated October 25, 2022, indicated R1 was to have his wound cleansed with normal saline, dab wound with Medi honey and cover with foam, then a thin layer of sacral meplex to be changed every three days and PRN (as needed). A review of R1's MAR/TAR for October 2022, included dressing change orders initiated on October 22, 2022, for Medi honey paste to be used with dressing changes every three days and as needed (PRN) for saturation. The order was documented as completed by facility staff on October 22, 25, and 28th. However, the MAR/TAR lacked specific instructions for wound care including cleaning the wound, and type of dressing to be applied. R1's October MAR/TAR had no documentation of wound monitoring, or repositioning being completed. On November 14, 2022, a hospice aide communication note to the facility indicated they requested a flow sheet for documenting R1's repositioning in bed. The record lacked documentation of a flow sheet for repositioning. R1's MAR/TAR for November 2022, included orders for Medi honey paste to be used with dressing changes every three days and as needed (PRN) for saturation. The order was documented as completed by facility staff daily from November 1, 2022, to November 8, 2022, then was discontinued. However, the MAR/TAR lacked specific instructions for wound care including cleaning the wound, and type of dressing to be applied. R1's October 2022, MAR/TAR had no documentation of wound monitoring, or repositioning being completed.	0 730		

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0 730	Continued From page 5 A review of R1's hospice record included documentation of hospice completing dressing changes, repositioning, and weekly wound observations. Although, hospice observed R1's wound weekly, the documentation lacked ongoing assessment of R1's wound to monitor progression and changes in R1's wound including size dept measurements odor drainage and peri wound area. On January 10, 2022, at 9:51 a.m. the licensed assisted living director (LALD)-A stated the facility had been keeping an eye on R1's pressure area, applying wound barrier cream, then it began to open up and got worse. LALD-A stated they left all wound care and monitoring up to hospice, and facility staff repositioned R1 every two hours. When asked if there was documentation for staff providing repositioning for R1, or services provided, LALD-A stated "most likely not". LALD stated there was no way to tell if repositioning was completed in the resident record, and indicated staff verbally reported to the next shift when R1 was last repositioned. The LALD stated she "did not feel like services provided had to be documented". On January 10, 2022, at 10:00 a.m. ULP-B stated the resident had a large deep pressure ulcer on his coccyx area that smelled bad with yellow watery drainage. ULP-B stated if R1's dressing fell off she would just "put it back on". ULP-B stated she repositioned R1 every two hours and indicated staff did not document cares provided anywhere. On January 12, 2023, 4:21 p.m. facility RN-C stated hospice was in charge of R1's pressure ulcer and she assumed they would measure and monitor R1's pressure ulcer status from week to	0 730		

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0 730	Continued From page 6 week. RN-C stated she reviewed hospice communication notes, but never reviewed R1's pressure ulcer wound assessments. RN-C stated staff provided repositioning every two hours, then reported off to the oncoming shift. RN-C stated staff did not document completing repositioning or services provided anywhere for her to monitor completion of tasks. RN-C stated R1's pressure ulcer progressed and got worse. RN-C indicated she never saw, assessed, or monitored R1's pressure ulcer. RN-C stated staff were to provide repositioning every two hours, but did not document completing repositioning anywhere for her to monitor if services were provided to the resident. RN-C stated staff verbally reported off to each other at the change of shift. On January 24, 2022, at 2:23 p.m. hospice RN-G stated when R1's coccyx pressure ulcer started it was just redness and was not open. RN-G stated the wound progressed and at times she was not sure the resident was being repositioned by facility staff. RN-G indicated R1 spent a lot of time in a recliner, and she provided education to staff with repositioning, using pillows to offload, and encouraging the resident to nap laying in his bed. RN-G stated she had concerns staff were not completing dressing changes according to orders, and indicated each staff member did things differently, and reported her concerns to LALD-A. RN-G stated initially the facility provided R1's wound care then as the wound progressed to a stage 4 hospice provided daily wound care. Documentation of the facilities wound assessment and ongoing monitoring was requested, none was provided. A facility policy for wound assessment, monitoring, and wound care was requested, none was provided. The facility provided various educational materials for	0 730		

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0 730	Continued From page 7 assessment and staging of a pressure ulcer wounds and a blank wound assessment and evaluation form. A change of condition assessment was requested for R1, none was provided. On January 12, 2023, a faxed communication from the facility indicated a change of condition assessment was not applicable for R1, indicating no assessment was completed when R1 was admitted to hospice with end-of-life care and after he developed pressure ulcers. A policy was requested for when to complete a change of condition assessment, none was provided. The facility provided a blank resident summary form, and indicated it would be completed on admission, with readmission, significant change, or other changes in the resident's condition. A facility provided policy and procedure titled "Content of the Client Records" dated January 2017, indicated in section E. home care assessments and service plans would identify vulnerabilities and interventions implemented. Section F. indicated the facility would maintain a record of communication pertinent to the client's services. Section G indicated the facility would document services provided as identified in the service plan. Section H. indicated the record would include documentation of monitoring of the client and client services by an RN. Section I. indicated the resident record would include documentation of significant change in client's status and actions taken in response to these changes including the following when appropriate.1. an updated assessment and vulnerability assessment including pertinent details of the resident's change of condition with date and time noted. 4. documentation of revision to the service plan and or vulnerabilities	0 730		

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0 730	Continued From page 8 interventions with new or revised orders. The licensee failed to ensure the contents of a resident record included the following: (4) treatments or therapies that required documentation, and other relevant health records; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident; (11) documentation services have been provided as identified in the service plan; (15) other documentation required under this chapter and relevant to the resident's services or status. A facility policy for documenting and recording information in the resident record was requested, none was provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	0 730		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview, and document review, the licensee failed to provide appropriate care and	02310		

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02310	Continued From page 9 services according to acceptable health care, medical, or nursing standards of practice for one of one residents (R1), reviewed for pressure ulcer wound care. The licensee failed to assess, monitor, and ensure interventions were implemented and communicated to staff to prevent new or worsening pressure ulcers. R1 was harmed when the pressure ulcer on his coccyx progressed, and the resident developed a stage 4 pressure ulcer wound with visible bone and muscle tissue. 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). Findings include: The National Pressure Ulcer Advisory Panel (NPUAP) resource dated 2016, defined a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. NPUAP defined a stage 1 pressure injury as non-blanchable erythema (redness) of intact skin with a localized area of non-blanchable erythema. A stage 2 pressure injury is defined as	02310		

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02310	Continued From page 10 partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. A stage 3 pressure injury is defined as full-thickness skin loss in which adipose (fat) tissue is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. A stage 4 pressure injury is defined as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer. R1 was admitted to the facility on July 27, 2021, with diagnoses including hypertension, cerebral arthrosclerosis, and vascular dementia. R1's hospice admission assessment and care plan dated September 19, 2022, indicated R1 had no open areas. R1's skin was pale in appearance with redness on his coccyx area, and staff were to apply barrier cream for protection and reposition R1 every two hours. R1's document titled "Summary - Annual Assessment" dated September 20, 2022, indicated R1 had fragile skin with a stage 1 pressure ulcer. The assessment indicated offloading, and repositioning would be done every two hours. The assessment indicated R1 was totally dependent on staff for ADL's including dressing, toileting, and incontinence care. The assessment indicated R1 needed staff assistance to reposition in bed every two hours, required a EZ stand mechanical lift for transfers, and was dependent on staff for mobility using a wheelchair.	02310		

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02310	Continued From page 11 R1's admission Vulnerability Assessment failed to indicate R1 was dependent on staff for ADL's including repositioning and transfers. The assessment indicated it was reviewed on September 20, 2022, when R1 was admitted to hospice but was not updated. R1's undated service agreement failed to include services the facility would provide. R1's undated care plan failed to indicate R1 required assistance with ADL's, including toileting, mobility, and repositioning every two hours following a change of condition when the resident was admitted to hospice for end-of-life care, and after developing pressure ulcers. The care plan failed to include wound monitoring of R1's pressure ulcer, wound care, and interventions implemented to prevent new or worsening pressure ulcers. R1's medication and treatment administration record (MAR/TAR) for September 2022, lacked documentation for wound monitoring, wound care, or repositioning being provided even though it was identified R1 had a pressure ulcer on September 19, 2022, when hospice ordered R1 to be repositioning every two hours. On October 3, 2022, a hospice communication note to the facility indicated R1's coccyx was breaking down. On October 4, 2022, a facility progress note indicated wound care to R1 pressure ulcer would be provided every seven days and PRN (as needed) by facility staff. The note indicated a hospice registered nurse (RN) would assess the wound weekly.	02310		

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02310	Continued From page 12 R1's after visit summary (AVS) and orders dated October 4, 2022, indicated a provider followed up on R1's pressure ulcer. The summary indicated R1 had a decline in functional status and required two staff assistance with a mechanical lift for transfers, assistance with ADLs, and received hospice end of life care. The summary indicated R1 had a stage 2 coccyx pressure ulcer that was being treated with offloading. On October 18, 2022, a hospice communication note to the facility indicated R1's coccyx pressure ulcer was not healing, and education was provided on repositioning. On October 23, 2022, a facility progress note indicated the client had a air mattress overlay on his bed, and Broada chair. The note indicated staff were encouraged to reposition R1 every two hours and PRN. A provider order dated October 25, 2022, instructed staff to cleanse R1's wound with normal saline, dab with Medi honey, cover with foam, then apply a thin layer of sacral Mepilex. The order indicated the dressing was to be changed every three days and PRN. On October 25, 2022, a hospice communication note to the facility indicated R1's sacral pressure ulcer was now a stage 3 and was worsening. On October 25, 2022, a facility progress note indicated facility staff were to change the pressure ulcer dressing every three days and PRN for saturation. R1's MAR/TAR for October 2022, included dressing change orders initiated on October 22, 2022, for Medi honey paste to be used with	02310		

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02310	Continued From page 13 dressing changes every three days and as needed (PRN) for saturation. The order was documented as completed by facility staff. However, the MAR/TAR lacked specific instructions for wound care including cleaning the wound, and type of dressing to be applied. R1's October MAR/TAR had no documentation of wound monitoring, or repositioning being completed. On October 27, 2022, at 8:00 a.m. a document titled "Nurses Medication Notes" indicated unlicensed personnel (ULP)-B provided wound care. On October 27, 2022, at 10:00 a.m. ULP-I documented completing wound care and dressing change because the dressing came off. On October 31, 22, at 2:30 p.m. ULP-B documented R1's dressing was changed because it fell off. On November 8, 2022, a hospice physician order indicated R1's pressure wound was a stage 3 pressure ulcer and indicated wound care to be provided by facility staff, and a hospice nurse would assess the wound weekly. On November 8, 2022, a AVS follow up indicated R1's pressure ulcer wound was rapidly worsening and indicated the wound was a stage 4 pressure ulcer, with visible bone and muscle fascia. On November 8, 2022, a facility progress note indicated R1 was to have wound care and dressing changes done by facility staff every other day and PRN for saturation. On November 13, 2022, a hospice communication note to the facility indicated R1 had a new stage 1 pressure area on his lower back, and instructed staff to reposition the	02310		

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02310	Continued From page 14 resident from side to side. The note indicated R1 required assistance from two staff with repositioning. On November 14, 2022, a hospice aide communication note to the facility indicated they requested a flow sheet for documenting R1's repositioning in bed. On November 15, 2022, a hospice physician order indicated R1 was to have Flagyl 500 mg tablet crushed then sprinkled topically into R1's coccyx pressure ulcer wound bed daily for wound drainage and odor. On November 16, 2022, a facility progress note indicated per hospice R1 had a stage 4 pressure ulcer with orders for a hospice nurse to change the dressing daily and PRN for saturation. The note indicated facility staff were to change R1's dressing PRN if saturated or soiled. On November 17, 2022, a hospice communication note indicated R1 had a new stage 2 wound on his mid spine, which had non-blanchable redness and staff were to apply foam dressing applied and change weekly and PRN. R1 was also noted to have non blanchable redness on his outer pinky toe and the resident was to wear heel protectors all times when in bed. On November 17, 2022, a facility progress note indicated hospice ordered R1 to wear heel protectors on his feet when in bed. The note indicated R1 had another stage 2 pressure ulcer on his middle back, with instructions to change the dressing every seven days and as needed for soiling. The note indicated facility staff were to manage PRN dressing changes.	02310		

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02310	Continued From page 15 R1's MAR/TAR for November 2022, included orders for dressing changes every three days and PRN for saturation. The order was documented as completed by facility staff daily from November 1, 2022, to November 8, 2022, then was discontinued. The MAR/TAR lacked orders for staff to complete PRN dressing changes as ordered. The MAR/TAR lacked any documentation of wound monitoring or repositioning being completed. A review of R1's hospice record indicated dressing changes, repositioning, and weekly wound assessments were completed. However, the weekly wound assessments failed to consistently include size, depth, measurements, and peri wound area monitoring. When interviewed on January 10, 2022, at 9:51 a.m. the licensed assisted living director (LALD)-A stated the facility had been keeping an eye on R1's pressure area, applying wound barrier cream, but then it began to open up and got worse. LALD-A stated they left all wound care and monitoring up to hospice, and facility staff repositioned R1 every two hours. When asked if there was documentation for staff providing repositioning for R1, or services provided, LALD-A stated "most likely not". LALD-A stated there was no way to tell if repositioning was completed in the resident record, and indicated staff verbally reported to the next shift when R1 was last repositioned. The LALD stated she "did not feel like services provided had to be documented". On January 10, 2022, at 10:00 a.m. ULP-B stated the resident had a large deep pressure ulcer on his coccyx area that smelled bad with yellow	02310		

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02310	Continued From page 16 watery drainage. ULP-B stated if R1's dressing fell off she would just "put it back on". ULP-B stated she repositioned R1 every two hours and indicated staff did not document care or services provided anywhere. On January 12, 2023, 4:21 p.m. facility RN-C stated hospice was in charge of R1's pressure ulcer wound, and she assumed they would measure and monitor R1's pressure ulcer status from week to week. RN-C stated she reviewed hospice communication notes, but never reviewed R1's pressure ulcer wound assessments. RN-C stated staff provided repositioning every two hours but did not document completing repositioning anywhere for her to monitor if services were provided to the resident. RN-C indicated she never saw, assessed, or monitored R1's pressure ulcer. On January 12, 2023, at 4:53 p.m. ULP- D stated she checked on R1 and repositioned him every two hours, as indicated on his care plan. ULP-D stated facility staff did not do anything with R1's wound care. On January 18, 2023, at 8:15 a.m. ULP-F stated R1's care plan and hospice notes instructed staff to reposition R1 every two hours, and hospice did everything with R1's wound care. On January 18, 2023, at 8:49 a.m. ULP-H stated hospice did R1's wound care. ULP-H stated staff were constantly repositioning R1. ULP-H stated R1's care plan and MAR included orders to turn and reposition R1 every two hours. On January 24, 2022, at 2:23 p.m. hospice RN-G stated when R1's coccyx pressure ulcer started it was reddened but intact. RN-G stated R1 was to	02310		

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02310	Continued From page 17 be repositioned every two hours, but R1's wound was getting worse, and she had concerns repositioning was not being done. RN-G stated she provided education to facility staff on repositioning. RN-G stated initially the facility provided wound care, then as the wound progressed hospice provided daily wound care. RN-G stated staff were not completing dressing changes according to orders and each staff member did things differently. RN-G stated when R1 became bed bound his coccyx wound was a stage 4 pressure ulcer, and hospice provided daily wound care. A facility provided policy and procedure titled "Content of the Client Records" dated January 2017, indicated in Section E. Home care assessments and service plans would identify vulnerabilities and interventions implemented. Section F. indicated the facility would maintain a record of communication pertinent to the client's services. Section G indicated the facility would document services provided as identified in the service plan. Section H. indicated the record would include documentation of monitoring of the client and client services by an RN. Section I. indicated the resident record would include documentation of significant change in client's status and actions taken in response to these changes including the following when appropriate. 1. an updated assessment and vulnerability assessment including pertinent details of the resident's change of condition with date and time noted. 4. documentation of revision to the service plan and or vulnerabilities interventions with new or revised orders. Documentation of facility wound assessment and ongoing monitoring was requested, none were provided. A facility policy for wound assessment	02310		

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02310	Continued From page 18 and wound care was requested, none was provided. The facility provided educational documentation for assessment and staging of a pressure ulcer and a blank wound assessment and evaluation form. A facility policy for documenting and recording information in the resident record was requested, none was provided. A change of condition assessment was requested for R1, none was provided. On January 12, 2023, a faxed communication from the facility indicated a change of condition assessment was not applicable for R1, indicating no assessment was completed when R1 was admitted to hospice with end-of-life care, and after he developed pressure ulcers. A policy was requested for when to complete a change of condition assessment none was received. The facility provided blank resident summary form, indicated it would be completed with an admission, readmission, with significant change, or other changes in the resident's condition. No additional information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		