Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL334262583M
Compliance #: HL334261757C

Date Concluded: July 29, 2024

Name, Address, and County of Licensee Investigated:
Wildwood Assisted Living
1420 2nd Street N 116
Sauk Rapids, MN 56379
Benton County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, 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 resident was neglected when the facility failed to provide appropriate care, services, monitoring, and wound care for pressure ulcers as ordered. As a result, the resident had poor wound healing of multiple stage 3 pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide wound care, monitoring, supervision, and implement ordered interventions to promote wound healing and reduce pressure. The facility failed to ensure unlicensed personnel (ULP) staff were trained and competent to provide wound care to the resident. The resident had two pressure ulcer wounds that progressively worsened after admission to the facility to stage 4 pressure ulcers with exposed bone.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident facility record(s), wound clinic records and photographs, home care records and photographs, and related facility policy and procedures. Also, the investigator observed the resident and staff at the facility.

The National Pressure Ulcer Injury Advisory Pannel (NPUIAP) defined a pressure injury as localized damage to the skin and underlying soft tissue usually over a bony prominence. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. NPUIAP defined a stage 4 pressure injury as full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer.

The resident resided in an assisted living facility with diagnoses including quadriplegia (paralysis of all 4 limbs) secondary to multiple sclerosis (a chronic disease damaging the myelin coating of nerves), type 2 diabetic, stroke, and left sided spastic hemiparesis (a condition causing involuntary muscle contractions). The resident required staff assistance with all activities of daily living.

The resident's wound care providers orders faxed 4 days after the resident's admission directed staff to provide daily and as needed (PRN) dressing changes to the resident's pressure ulcers.

Ongoing provider faxed orders included various changes to the resident's wound care and dressing change instructions. The orders included instructions for staff to implement measures to decrease pressure, friction, and sheering by limiting linens under the resident and keeping the head of the resident's bed at less than 30 degrees. The orders indicated the resident should spend most of his time in bed, with repositioning side to side every 2 hours and PRN, and indicated the resident was to be up in his wheelchair for meals only to reduce the pressure.

The resident's admission assessment completed 12 days after the resident was admitted to the facility indicated the resident had pressure ulcers on his ischial tuberosity and coccyx area. The admission assessment indicated the resident required wound treatment, dressing changes, and repositioning every 2 hours with scheduled offloading times. The assessment indicated an outside agency managed the resident's wounds.

Two days later the resident's 14-day assessment was completed and indicated the resident had only one pressure ulcer on his coccyx area. The assessment indicated the resident would be repositioned every 2 hours while up in his wheelchair for offloading and staff would transfer the resident to bed for mid-day offloading. The assessment indicated the facility did not provide any wound care or dressing changes to the resident. The assessment indicated outside skilled nursing, not the facility staff, would evaluate and treat the resident's pressure wounds.

Three months and 11 days after admission to the facility, a new assessment completed after a hospital readmission indicated the resident had pressure ulcers on his coccyx and ischial

tuberosity. The assessment indicated the resident required dressing changes twice daily, turning and repositioning every 2 hours, scheduled offloading, and a pressure relieving cushion in his wheelchair. The assessment indicated the resident was up at 8:00 a.m. and offloaded in bed for 1 hour during the day, then was in bed for the night around 9:45 p.m. indicating the resident offloaded for only one hour during the day. The assessment failed to include ordered interventions to decrease pressure, friction, and sheering, and failed to indicate the resident should be offloaded in bed and repositioned every 2 hours and PRN, with the resident up in his chair for mealtimes only. The assessment indicated the resident required skilled nursing oversight with complex wound care dressing changes.

The resident's service plan indicated ULP staff provided daily wound dressing changes. The residents service plan lacked provider orders and instructions for wound care, dressing changes, and other interventions ordered to promote wound healing and reduce pressure, friction, and sheering, including offloading the resident primarily in bed with repositioning side to side with the resident in his wheelchair for meals only. The service plan indicated the registered nurse (RN) would provide monthly wound care supervision, and a Licensed Practical Nurse (LPN) would provide wound care 3 days per week.

The resident's care plan indicated the resident had pressure ulcers and staff were directed to reposition the resident every 2 hours for offloading while the resident was up in his wheelchair, and instructed staff to transfer the resident to bed mid-day. The care plan lacked instructions for wound care, dressing changes, and other ordered interventions to reduce pressure, friction, and sheering including offloading the resident primarily in bed with repositioning side to side with the resident in his wheelchair for meals only. The care plan failed to indicate wound care was provided by the facility, and indicated the resident's wounds were managed by an outside agency.

The facility RN indicated via email the facility had no orders for wound care or dressing changes to be completed until 4 days after the resident was admitted to the facility with pressure ulcers. The RN indicated wound care completed in January and February was documented under a service titled "bed rail alert."

The bed rail alert service delivery record included documentation of dressing changes completed by the facility from the day the resident was admitted on January 25, 2024, to February 13, 2024. The service included instructions to complete wound care orders as written (4 days before the facility received orders for dressing changes).

The service record lacked specific direction to staff to include providers orders for wound care and instructions on how to complete the resident's dressing changes. As a result, there was no way to determine what wound care was provided to the resident by the facility. The resident's services and service documentation lacked any instruction to staff, and there was no indication dressing change orders and instructions were visible to staff when the service was provided.

Email correspondence with the facility RN indicated new dressing change orders were highlighted and flagged for staff to review in the system independently.

The resident's wound dressing change services for March through June initiated on March 15, 2024, indicated no wound care was provided to the resident as ordered from February 13, 2024, to March 15, 2024. The service delivery record from March to June lacked specific direction to staff to include providers orders for wound care and instructions on how to complete the resident's dressing changes.

The residents service record indicated the LPN documented dressing changes were provided 6 of the 13 times scheduled in March, 1 of 13 times in April, and indicated the LPN provided no dressing changes in May or June.

The resident record lacked any documentation of an RN completing monthly wound care supervision.

The resident's progress notes were reviewed and lacked any documentation by the facility RN that included ongoing wound assessment, monitoring, or supervision of dressing changes delegated and completed by ULP staff.

The resident's service reports failed to indicate the facility implemented offloading the resident primarily in bed with repositioning side to side every 2 hours, with a minimal amount of time up in his wheelchair. The report failed to indicate interventions to reduce pressure, friction, and sheering to promote wound healing were implemented by the facility.

During interview and email correspondence the facility RN stated she was aware the resident was only to be up for meals and indicated the resident was non-compliant with offloading and repositioning every 2 hours until recently despite the resident record having no indication offloading was implemented by the facility as ordered by the provider. The RN indicated the facility did not provide ongoing wound assessment or monitoring. The RN indicated the LPN provided dressing changes for a short time. The facility RN indicated she was unable to provide a report to show RN supervision of delegated services was provided. The RN stated the resident's wounds were no worse and had not changed since admission.

The residents outside home care record indicated the resident was admitted for wound care of the resident's stage 3 ischial, and sacral pressure ulcers.

Numerous home care visit notes indicated the residents open pressure ulcer wounds were repeatedly observed by home care staff with no dressing in place, with incontinent stool causing the residents bottom to be bright red, raw, with fecal matter in the pressure ulcer wound beds. The documentation indicated the resident expressed ULP staff were not completing dressing changes as ordered. The record indicated when the home care nurses expressed their concern to facility staff, they indicated the resident had no dressing change

supplies, and they were not trained to complete the residents wound care. One note (42 days after the resident was admitted to the facility with orders for wound care) indicated the facility RN planned to train ULP staff later in the week. The home care record indicated after reporting concerns to the facility, the resident's wounds continued to have no dressing on them with fecal matter present in the wound beds.

A review of photographs from the resident's home care record showed bright red raw skin, with no dressings on the resident's wounds, and fecal matter in the resident's wound beds.

When interviewed several home health nurses who provided wound care for the resident indicated the facility was directed to provide wound care daily and PRN. The nurses stated ULP staff, and the resident reported concerns with the lack of ULP staff training, and indicated the resident's dressing changes were not done as ordered. The nurses stated on multiple occasions they arrived at the facility and the resident was left with incontinent stool, the resident's pressure ulcer wounds frequently had no dressings on them, or the dressings were done incorrectly with no packing into the pressure ulcers which caused fecal matter to enter the resident's pressure ulcer wound beds. The nurses indicated the facility RN was uninvolved in the resident's wound care, wound monitoring, stated she was unable to provide wound care for the resident, and became defensive when concerns regarding the resident's wound care were expressed. The nurses indicated the facility staff had not been trained to provide wound care, specifically the complex wound care the resident was receiving as the pressure ulcers continued to worsen.

When interviewed another homecare nurse indicated the facility RN had not been present when the resident's wounds were assessed or while dressing changes were completed. The nurse indicated the facility RN never assessed or monitored the resident's wounds or observe wound care completed by the ULP staff. The nurse indicated the facility RN was expected to be involved and assessing the resident's wounds to ensure dressing changes delegated to ULP staff were completed and done correctly.

The residents outside wound clinic documentation and photographs indicated prior to admission to the facility the resident's wounds included an unstageable pressure ulcer with the wound onset date of January 16, 2024, (just prior to admission to the facility) on the resident's left ischial tuberosity, and a stage 3 coccyx pressure ulcer that was 65% healed. On March 26, 2024, the resident's pressure ulcers were both a stage 3. On February 13, 2024, the record indicated the resident should spend most of his time in bed with side-to-side repositioning and a minimal amount of time in his wheelchair. However, the record indicated the resident continued to repeatedly report to the provider he was spending a significant amount of time up in his wheelchair (4 to 8+ hours per day).

In June the residents outside medical record indicated the resident's wounds continued to deteriorate and had worsened to stage 4 non healing pressure ulcers with undermining, and

exposed boney structures present. In addition, an MRI completed at that time identified concerns of osteomyelitis (a severe bone infection).

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: N/A

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.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Benton County Attorney
Sauk Rapids City Attorney
Sauk Rapids Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33426	A. BUILDING: _____ B. WING _____	C 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONEY VIEW ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, 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: #HL334262583M/ #HL334261757C On June 10, 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 20 residents receiving services under the provider's Assisted Living Facility license. The following correction orders were issued for #HL334262583M/ #HL334261757C, tag identification 1420, 1940, 2320, and 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.	
01420 SS=G	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 1 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure 1 of 1 resident, R1, reviewed for a pressure ulcer had a registered nurse (RN) or licensed health professional trained and had documentation unlicensed personnel (ULP) staff had demonstrated competency in the proper methods to perform tasks and procedures specific to each resident as ordered by the provider and delegated to ULP staff for one of one resident (R1) who received wound care for pressure ulcers. This resulted in harm for R1 when ULP staff were not trained to provided specific wound care for the residents pressure ulcers and the resident developed a stage 4 pressure ulcer with exposed bone. 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	01420		

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01420	Continued From page 2 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 January 25, 2024, with diagnoses including quadriplegia (paralysis of all 4 limbs) secondary to multiple sclerosis (a chronic disease damaging the myelin coating of nerves), type 2 diabetic, stroke, and left sided spastic hemiparesis (a condition causing involuntary muscle contractions). On January 29, 2024, (4 days after admission) R1's faxed wound care orders to the facility included instruction for pressure ulcer wound care to be provided to R1's pressure ulcer wounds. The orders indicated the right ischial pressure ulcer was to have a thin layer of triad paste to the ulcer bed and peri wound area, covered by an ABD pad and secured with R1's brief. The orders indicated R1's left ischial ulcer was to have a thin layer of triad paste to the peri ulcer area, non-selective debridement using therahoney to the ulcer bed and instructed staff to apply therahoney to a 2 X 2 coarse gauze then tuck into the depth of the ulcer. The orders included instructions for staff to apply Vaseline to R1's coccyx ulcer, apply an ABD and secure with R1's brief. The orders indicated R1's dressings should be changed daily and as needed if soiled or loose. On February 13, 2024, R1's faxed wound care orders to the facility included instructions for R1's right ischial ulcer and all areas of breakdown on R1's buttocks, apply a thin layer of triad paste to the ulcer bed and peri ulcer areas, then cover	01420		

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01420	Continued From page 3 with an ABD and secure with R1's brief. For R1's left ischial ulcer and coccyx ulcers staff should apply a thin layer of triad paste to the peri ulcer area, non-selective debridement via course gauze slightly moistened with saline and gently tucked into the ulcer beds then covered with an ABD. The orders indicated R1's dressings should be changed daily and as needed if soiled or loose. On March 8, 2024, R1's faxed wound care orders to the facility indicated R1's right ischial ulcer and all areas of breakdown on bilateral buttocks and scrotum should have Nystatin powder and cover with barrier cream. The orders instructed to apply PRN with brief changes to ensure skin stays clean and dry. The orders indicated the left ischial and coccyx ulcers should have a thin layer of calamine paste to the peri ulcer area, and instructed staff to tuck dry coarse gauze into the pressure ulcer wound bed, then cover with ABD. The orders indicated staff should change all R1's dressings daily and PRN if soiled or loose. On April 9, 2024, R1's faxed wound care orders to the facility included instruction to all areas of breakdown on bilateral buttocks and scrotum staff should apply a light layer of barrier cream, apply as needed (PRN) with brief changes to ensure skin stays clean and dry and indicated staff may alternate with A&D ointment or Vaseline if R1's skin became too dry. The orders indicated to R1's left ischial and coccyx pressure ulcers staff should apply a thin layer of calamine paste to R1's peri ulcer area and provide nonselective debridement via coarse gauze dampened with saline to the ulcer bed (2 X 2 gauze used in the coccyx ulcer), cover with ABD pad, secured with paper tape. The orders indicated R1's dressings should be changed twice daily and PRN if soiled	01420		

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01420	Continued From page 4 or loose, and instructed staff to not scrub off the cream, and indicated if there was a layer present do not add more. On April 16, 2024, R1's faxed wound care orders to the facility included instructions to all areas of irritation/redness on bilateral buttocks and scrotum staff should apply a mixture of triamcinolone cream and calamine. The orders instructed to apply the mixture daily with dressing changes to ensure skin stays clean and dry. To R1's left ischial and coccyx ulcers staff should apply a thin layer of the cream mixture to R1's peri ulcer areas. Provide debridement via Santyl, nickel thickness to wounds followed by coarse fluffed gauze to ulcer beds (2 X 2) used in the coccyx ulcer bed, cover with ABD and secure with paper tape. Wash off Santyl and reapply daily. On April 23, 2024, R1's faxed wound care orders to the facility included instructions to all areas of irritation apply a 50/50 mixture of Miconazole powder (nystatin) and calazime daily with dressing changes, and brief changes to ensure skin stays clean and dry. To R1's left ischial and coccyx ulcer apply a layer of the mixture to peri ulcer areas, and provide debridement via Santyl, nickel thickness, followed by coarse fluff gauze (do not moisten) to ulcer beds (2 X 2 gauze to coccyx and left ischial) do not over pack. Cover with ABD and secure with brief, wash off Santyl and reapply daily. On May 7, 2024, R1's faxed wound care orders to the facility included instructions to apply the 50/50 mixture of miconazole and calazime to peri ulcer areas. Provide wound debridement via damp to dry dressing using gauze and normal saline to wound beds. Apply course fluff gauze saline moistened to ulcer beds (2 X 2 gauze used in	01420		

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01420	Continued From page 5 coccyx ulcer, and 4X4 gauze used in left ischial ulcer) do not over pack, cover with ABD. Change dressings daily and PRN if soiled or dislodged. A facility provided document titled "wound notes" included some of R1's dressing change instructions from March 14, 2024, April 5, 2024, May 6, 2024, and May 7, 2024, the wound notes did not match the providers orders and instructions or include updated orders and instructions with each of R1's order changes. On June 26, 2024, at 4:54 p.m. an email correspondence with Registered Nurse Clinical Nurse Supervisor (RNCNS)-F indicated new dressing change orders were highlighted and flagged for staff to review in the system independently. R1's services, and service reports lacked any wound care instructions, as a result there was no indication R1's dressing change instructions were visible to staff when the service was provided. On June 21, 2024, at 1:46 p.m. email correspondence with RNCNS-F indicated the licensee had no orders for wound care or dressing changes to be completed until 4 days after R1 was admitted to the facility with pressure ulcers. RNCNS-F indicated wound care completed in January and February was documented under a service titled "bed rail alert". The bed rail alert service delivery record was reviewed which included documentation of dressing changes completed by the facility from the day R1 was admitted on January 25, 2024, to February 13, 2024. The service included instructions to complete wound care orders as written (4 days before the facility had orders for dressing changes). The service record lacked specific direction to staff to include providers	01420		

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01420	Continued From page 6 orders for wound care and instructions on how to complete R1's dressing changes. As a result, there is no way to know what wound care was provided to R1 by the facility. R1's service delivery record for wound dressing change services from March 2024, through June 2024, were reviewed and indicated the service was not initiated until March 15, 2024, indicating no wound care was provided to R1 as ordered from February 13, 2024, to March 15, 2024. The service delivery record lacked specific direction to staff to include providers orders for wound care and instructions on how to complete R1's dressing changes. As a result, there is no way to know what wound care was provided to R1 by the facility. On June 25, 2024, at 3:59 p.m. RNCNS-F stated she had trained ULP staff on wound care and dressing changes in groups, during inservices, and individually. RNCNS-F stated she had staff demonstrate individual skill competencies, and completed staff supervision for each or the residents specific wound care dressing order changes. RNCNS-F indicated after training was completed with each order change she sent communication updates in R1's wound notes. RNCNS indicated she would provide documentation to show training, competency, and supervision was completed for R1's delegated wound care as ordered by the provider. Training and competency records for 5 ULP staff who documented providing wound care to R1 was requested. The documentation provided by RNCNS-F showed some staff had generalized wound care training. The documentation lacked any skills or competency specific to R1's providers orders to ensure R1's wound care dressing changes were done correctly, and with	01420		

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01420	Continued From page 7 each subsequent order change. The documentation failed to show supervision of wound care and dressing changes delegated to ULP staff was provided. 1. ULP-K's training and competency documentation included an undated unsigned in service training certificate on February 7, 2024, which included generalized wound care training. A facility in service certificate on April 24, 2024, included training for wound care wet to dry review, and Santyl placement. The unsigned and undated documents failed to show ULP-K had completed the training. In addition, ULP-K's training failed to show the staff had completed skills competency to do the procedures ordered by R1's provider. The facility in service training's certificated lacked training and competency specific to R1's dressing changes and wound care instructions as ordered by R1's provider. 2. ULP-L training and competency was requested, none was provided. On June 26, 2024, at 12:03 p.m. Email communication from RNCNS-F on June 26, 2024, at 12:03 p.m. indicated ULP-L was a contracted staff who picked up shifts, had not been tested out on wound care at the facility, and should not have completed wound care for R1. 3. ULP-D's training and competency documentation included an Educare transcript titled "Skill Competency" the transcript included generalized basic education on wound care completed on April 17, 2023. An unsigned undated facility in service certificate indicated generalized wound care training was provided on January 27, 2024. An unsigned undated facility in service certificate included training for wound care wet to dry review, and Santyl placement on	01420		

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01420	Continued From page 8 April 24, 2024. The unsigned and undated documents failed to show ULP-D had completed the training. In addition, ULP-D's training failed to show the staff had completed skills competency to do the procedures ordered by R1's provider. The facility in service training's certificated lacked training and competency specific to R1's dressing changes and wound care instructions as ordered by R1's provider. 4. ULP-M's training and competency documentation included an unsigned undated certificate of completion for in service training on March 7, 2024, which included generalized wound care education. An unsigned undated in service training certificate on April 5, 2024, for wet to dry wound care. An unsigned undated certificate of in service training for wound care, wet to dry, and Santyl placement on April 24, 2024. The training documents were not signed or dated as a result there was no indication ULP-M completed the training. In addition, ULP-M's training failed to show skills and competency to do the procedures as ordered by R1's provider. The facility in service training's certificated lacked training and competency specific to R1's dressing changes and wound care instructions as ordered by R1's provider. 5. ULP-E's training and competency documentation included and unsigned undated in service training certificate on 2/7/2024, which included generalized wound care. An unsigned undated certificate of in service training for wound care, wet to dry, and Santyl placement on April 24, 2024. The document was not signed or dated as a result there was no indication ULP-E completed the training. In addition, ULP-E's training failed to show skills and competency to do the procedures ordered by R1's provider. The	01420		

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01420	Continued From page 9 facility in service training's certificated lacked training and competency specific to R1's dressing changes and wound care instructions as ordered by R1's provider. On June 26, 2024, at 9:43 a.m. Homecare RN-J stated Homecare staff provided wound care and dressing changes 3 times per weekly and licensee staff were to provide R1's wound care and dressing changes when the Homecare nurses were not there. RN-J stated R1 had fecal matter in his wounds because wound care and dressing changes were not provided by licensee staff. RN-J stated R1 reported to Homecare nursing staff he had not been repositioned or offloaded as ordered, and licensee staff had only completed dressing changes 2 times in a month. RN-J stated Homecare nurses reported concerns of R1's dressing changes not being done to facility staff who stated they were not providing R1's wound care because they had not been trained. On June 26, 2024, at 4:29 p.m. Homecare RN-K stated ULP staff were not completing R1's dressing changes as ordered. RN-K stated R1 was often found on numerous occasions with incontinent stool, no dressing in place, and fecal matter in R1's pressure ulcer wound beds. RN-K indicated she had reported the concerns to RNCNS-F who stated the licensee's ULP staff needed to be trained. On June 26, 2024, at 8:33 a.m. Homecare LPN-A stated she was seeing R1 twice weekly pressure ulcer wound care on his bottom. LPN-A stated on multiple occasions she observed no dressing in place, R1 was often incontinent of stool, and had fecal matter in the pressure ulcer wound beds. LPN-A indicated R1 had frequent	01420		

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01420	Continued From page 10 loose bowel movements and R1's pressure ulcers were near the rectum and prone to become soiled frequently. LPN-A stated R1's wound care orders indicated the dressings should be changed when soiled or dislodged, but those orders were not followed by the licensee staff. LPN-A stated R1 and multiple ULP staff had reported on numerous occasions R1's dressing changes were not being done because the facility had no supplies, and staff were not trained to provide wound care to R1. LPN-A stated she would left dressing supplies for staff, but they continued to not provide dressing changes to R1. LPN-A stated R1's pressure ulcer wounds progressively worsened. On June 27, 2024, at 12:38 p.m. Homecare RN-B stated she provided weekly dressing changes and wound monitoring for R1's pressure ulcers. RN-B stated the facility ULP staff were to provide dressing changes but it was not getting done, or was done incorrectly. RN-B stated R1 and ULP staff reported they were not trained to complete the dressing changes, and they had no supplies. RN-B stated R1's wounds often had no dressing, or no packing in the wound bed allowing fecal matter to enter the pressure ulcers. RN-B stated she would leave supplies for staff to complete dressing changes. RN-B stated RNCNS-F stated she was unable to provide wound care or dressing changes to R1, and indicated ULP staff were to provide R1's wound care. R1's outside medical record indicated prior to admission to the facility R1's wounds included an unstageable pressure ulcer with the wound onset date of January 16, 2024, (prior to admission to the facility) on R1's left ischial tuberosity, and a stage III coccyx pressure ulcer that was 65% healed. On March 26, 2024, R1's pressure ulcers	01420		

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01420	Continued From page 11 were both a stage III. On February 13, 2024, R1's orders indicated R1 should spend most of his time in bed with side-to-side repositioning and a minimal amount of time in his wheelchair. However, the record indicated R1 continued to repeatedly report to the provider he was spending a significant amount of time up in his wheelchair (4 to 8+ hours per day). In June R1's outside medical record indicated R1's wounds continued to deteriorate and had worsened to stage 4 non-healing pressure ulcers with undermining, and exposed bony structures present. In addition, an MRI completed at that time identified concerns of osteomyelitis (a severe bone infection). The facility policy titled "Delegation of Nursing Tasks" reviewed February 13, 2023, indicated nursing tasks would be appropriately delegated to unlicensed personnel using the licensed staff professional judgment. Section 1. indicated a RN may delegate nursing services if they had successfully completed training for the service to be provided and demonstrated the ability to competently follow the procedures and skills consistent with the complexity of the task. The delegation of treatments indicated the RN would develop and maintain a current individualized treatment record and instruct unlicensed staff in the proper methods to provide treatment or perform tasks and determine unlicensed personnel have demonstrated the ability to competently follow procedures. Section 5. indicated before delegating a task to unloosened staff each staff member would perform the task and had been instructed in the proper procedures. The RN would document each staff received this instruction and sign off to attest each staff had read and understood the instructions prior to providing the service. The RN will ensure training and competency records are	01420		

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01420	Continued From page 12 kept up to date for all unlicensed staff and easily accessible to determine which staff are competent to perform various delegated tasks. Section 6. Indicated the RN would establish, implement, and update a system to communicate unlicensed staff and their competencies to determine the appropriateness of delegating tasks. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	01420		
01940 SS=G	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 13 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure accurate and timely management of ordered treatments to include in the service plan a written statement of services that will be provided to the resident, and a current up to date individualized treatment and therapy management record with the required content for each resident as ordered to promote wound healing for 1 of 1 resident's (R1) admitted with pressure ulcers. R1 was harmed when two pressure ulcers progressively worsened to stage 4 pressure ulcers with exposed bone. 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: R1 was admitted to the facility on January 25, 2024, with diagnoses including quadriplegia (paralysis of all 4 limbs) secondary to multiple sclerosis (a chronic disease damaging the myelin	01940		

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01940	Continued From page 14 coating of nerves), type 2 diabetic, stroke, and left sided spastic hemiparesis (a condition causing involuntary muscle contractions). On January 25, 2024, the resident's admission service agreement included wound care completed by a Licensed Practical Nurse (LPN) weekly and indicated the Registered Nurse (RN) would complete monthly wound care supervision. The service plan failed to include daily wound care and dressing changes. On January 29, 2024, (4 days after admission) R1's faxed wound care orders to the facility included instruction for pressure ulcer wound care to be provided to R1's pressure ulcer wounds. The orders indicated the right ischial pressure ulcer was to have a thin layer of triad paste to the ulcer bed and peri wound area, covered by an ABD pad and secured with R1's brief. The orders indicated R1's left ischial ulcer was to have a thin layer of triad paste to the peri ulcer area, non-selective debridement using therahoney to the ulcer bed and instructed staff to apply therahoney to a 2 X 2 coarse gauze then tuck into the depth of the ulcer. The orders included instructions for staff to apply Vaseline to R1's coccyx ulcer, apply an ABD and secure with R1's brief. The orders indicated R1's dressings should be changed daily and as needed if soiled or loose. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be turned and repositioned every 2 hours and as needed (PRN). On February 5, 2024, R1's first admission assessment completed 11 days after R1 was	01940		

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01940	Continued From page 15 admitted to the facility indicated R1 had a stage 4 pressure ulcers one on his right ischial tuberosity, and an unstageable wound on his coccyx area. The assessment indicated R1 required wet to dry dressing change twice daily (BID), and staff were to apply skin barrier cream to peri wound area, turning and reposition R1 every 2 hours with scheduled offloading times, and indicated R1 used a pressure relieving cushion in R1's wheelchair. The assessment failed to accurately identify R1's wound care/dressing change needs as ordered, and other interventions to reduce pressure, friction, shearing and promote wound healing. Two days later on February 7, 2024, R1's 14-day assessment was completed which indicated R1 only had one pressure ulcer on his coccyx area. The assessment failed to identify R1 required dressing changes and had no interventions for the treatment of R1's pressure ulcers injuries other than to provide pressure reduction measures to R1's buttocks. The assessment indicated skilled nursing would evaluate and treat R1's pressure wounds. The assessment failed to accurately identify R1's pressure ulcers, wound care/dressing change needs as ordered, and other interventions to reduce pressure, friction, shearing and promote wound healing. On February 13, 2024, R1's faxed wound care orders to the facility included instructions for R1's right ischial ulcer and all areas of breakdown on R1's buttocks, apply a thin layer of triad paste to the ulcer bed and peri ulcer areas, then cover with an ABD and secure with R1's brief. For R1's left ischial ulcer and coccyx ulcers staff should apply a thin layer of triad paste to the peri ulcer area, non-selective debridement via course gauze slightly moistened with saline and gently	01940		

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01940	Continued From page 16 tucked into the ulcer beds then covered with an ABD. The orders indicated R1's dressings should be changed daily and as needed (PRN) if soiled or loose. The orders indicated R1 should be in his bed and repositioned side to side every 2 hours, with R1 only be up in his wheelchair for 30-45 minutes at mealtimes only. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be turned and repositioned every 2 hours and as needed (PRN). On February 21, 2024, R1's faxed wound care orders to the facility remained unchanged from the February 13, 2024, orders. On March 8, 2024, R1's faxed wound care orders to the facility indicated R1's right ischial ulcer and all areas of breakdown on bilateral buttocks and scrotum should have Nystatin powder and cover with barrier cream. The orders instructed to apply PRN with brief changes to ensure skin stays clean and dry. The orders indicated the left ischial and coccyx ulcers should have a thin layer of calazime paste to the peri ulcer area, and instructed staff to tuck dry coarse gauze into the pressure ulcer wound bed, then cover with ABD. The orders indicated staff should change all R1's dressings daily and PRN if soiled or loose. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and PRN. The orders indicated R1 should be up	01940		

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01940	Continued From page 17 in his chair for mealtimes only. On March 13, 2024, the resident's faxed wound care orders to the facility remained unchanged from the March 8, 2024, orders. On March 20, 2024, the resident's faxed wound care orders to the facility remained unchanged from the March 8, 2024, orders. On March 26, 2024, the resident's faxed wound care orders to the facility remained unchanged from the March 8, 2024, orders. On April 9, 2024, R1's faxed wound care orders to the facility included instruction to all areas of breakdown on bilateral buttocks and scrotum staff should apply a light layer of barrier cream, apply as needed (PRN) with brief changes to ensure skin stays clean and dry and indicated staff may alternate with A&D ointment or Vaseline if R1's skin became too dry. The orders indicated to R1's left ischial and coccyx pressure ulcers staff should apply a thin layer of calazime paste to R1's peri ulcer area and provide nonselective debridement via coarse gauze dampened with saline to the ulcer bed (2 X 2 gauze used in the coccyx ulcer), cover with ABD pad, secured with paper tape. The orders indicated R1's dressings should be changed twice daily and PRN if soiled or loose, and instructed staff to not scrub off the cream, and indicated if there was a layer present do not add more. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and as needed (PRN).	01940		

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01940	Continued From page 18 The orders indicated R1 should be up in his chair for meal times only. On April 16, 2024, R1's faxed wound care orders to the facility included instructions to all areas of irritation/redness on bilateral buttocks and scrotum staff should apply a mixture of triamcinolone cream and calazime. The orders instructed to apply the mixture daily with dressing changes to ensure skin stays clean and dry. To R1's left ischial and coccyx ulcers staff should apply a thin layer of the cream mixture to R1's peri ulcer areas. Provide debridement via Santyl, nickel thickness to wounds followed by coarse fluffed gauze to ulcer beds (2 X 2) used in the coccyx ulcer bed, cover with ABD and secure with paper tape. Wash off Santyl and reapply daily. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of the R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and as needed (PRN). The orders indicated R1 should be up in his chair for meal times only. On April 23, 2024, R1's faxed wound care orders to the facility included instructions to all areas of irritation apply a 50/50 mixture of Miconazole powder (nystatin) and calazime daily with dressing changes, and brief changes to ensure skin stays clean and dry. To R1's left ischial and coccyx ulcer apply a layer of the mixture to peri ulcer areas, and provide debridement via Santyl, nickel thickness, followed by coarse fluff gauze (do not moisten) to ulcer beds (2 X 2 gauze to coccyx and left ischial) do not over pack. Cover with ABD and secure with brief, wash off Santyl	01940		

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01940	Continued From page 19 and reapply daily. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and as needed (PRN). The orders indicated R1 should be up in his chair for meal times only. On May, 6, 2024, a hospital readmission assessment identified R1 had pressure ulcers, and required dressing changes twice daily. R1 was up at 8:00 a.m. and in bed for 1 hour during the day, then went to bed around 9:45 p.m. The assessment indicated R1 required periodic repositioning for offloading every 2 hours while up in his chair. The readmission assessment indicated R1 required skilled nursing oversight with complex wound care dressing changes. The assessment failed to identify R1's wound care/dressing change needs as ordered, and other interventions to reduce pressure, friction, shearing and promote wound healing including, and failed to indicate R1 should be offloaded in bed and repositioned every 2 hours and PRN, with R1 up in his chair for mealtimes only. On May 7, 2024, R1's faxed wound care orders to the facility included instructions to apply the 50/50 mixture of miconazole and calazime to peri ulcer areas. Provide wound debridement via damp to dry dressing using gauze and normal saline to wound beds. Apply course fluff gauze saline moistened to ulcer beds (2 X 2 gauze used in coccyx ulcer, and 4X4 gauze used in left ischial ulcer) do not over pack, cover with ABD. Change dressings daily and PRN if soiled or dislodged. The orders included instructions for staff to	01940		

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HARMONEY VIEW ASSISTED LIVING	1420 2ND STREET NORTH SAUK RAPIDS, MN 56379

(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
01940	Continued From page 20 reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under the resident, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and PRN. The orders indicated R1 should be up in his chair for meal times only. R1 Service agreement dated April 1, 2024, indicated staff would provide wound care and dressing changes daily. The service agreement indicated repositioning was provided 12 times daily, and indicated an RN provided wound care supervision monthly, and dressing changes supervision 3 days a week, and an LPN would complete wound care 3 days a week. The service agreement failed to indicate wound care would be delegated and completed by unlicensed personnel (ULP) staff. The service plan failed to include interventions for staff to implement to reduce pressure, friction, and shearing, and failed to indicate R1 should be offloaded in bed with turning and repositioning provided every 2 hours and PRN, and only up in his chair for meal times. R1's care plan identified R1 had pressure ulcers and indicated staff should reposition the resident every 2 hours for offloading while he was up in his wheelchair. The care plan instructed staff to transfer the resident to bed mid-day. The care plan lacked instructions for physician ordered interventions to reduce pressure, friction, and sheering including offloading R1 primarily in bed with repositioning side to side with R1 in his wheelchair for meals only. The care plan failed to indicate wound care was provided by the facility, had no wound care instructions included in the R1's plan of care for staff to implement, and	01940		

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01940	Continued From page 21 indicated R1's wounds were managed by an outside agency. On entrance June 10, 2024, the resident's treatment administration record (TAR) was requested, the TAR was repeatedly requested, none was provided. On June 21, 2024, at 1:46 p.m. email correspondence with RN Clinical Nurse Supervisor (RNCNS)-F indicated the licensee had no orders for wound care or dressing changes to be completed until 4 days after R1 was admitted to the facility with pressure ulcers. RNCNS-F indicated wound care completed in January and February was documented under a service titled "bed rail alert". R1's bed rail alert service delivery record was reviewed which included documentation of dressing changes completed by the facility from the day R1 was admitted on January 25, 2024, to February 13, 2024. The service included instructions to complete wound care orders as written (4 days before the facility had orders for dressing changes). The service record lacked specific direction to staff to include providers orders for wound care and instructions on how to complete R1's dressing changes. As a result, there is no way to know what wound care was provided to R1 by the facility. R1's service delivery record for wound dressing change services from March 2024, through June 2024, were reviewed and indicated the service was not initiated until March 15, 2024, indicating no wound care was provided to R1 as ordered from February 13, 2024, to March 15, 2024. The service delivery record lacked specific direction to staff to include providers orders for wound care	01940		

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01940	Continued From page 22 and instructions on how to complete R1's dressing changes. As a result, there is no way to know what wound care was provided to R1 by the facility. R1's service reports failed to indicate the licensee implemented ordered interventions for wound healing including offloading R1 primarily in bed with repositioning side to side every 2 hours, with a minimal amount of time up in his wheelchair. The service reports failed to indicate interventions to reduce pressure, friction, and sheering to promote wound healing were implemented by the licensee. Although R1's service plan indicated an RN provided monthly wound care supervision, and an LPN provided wound care dressing changes 3 days per week. The service record indicated the LPN's service was provided 6 of the 13 times scheduled in March 2024, 1 of 13 times in April 2024, and indicated the service was not provided in May or June 2024. The record lacked any documentation of an RN completing monthly wound care supervision. R1's progress notes were reviewed and lacked any documentation of the facility RN completing ongoing wound assessment, monitoring, or supervision of dressing changes delegated and completed by ULP staff. A facility provided document titled "wound notes" included some of R1's dressing change instructions from March 14, 2024, April 5, 2024, May 6, 2024, and May 7, 2024, the wound notes did not match the providers orders and instructions or include updates when the orders changed. On June 26, 2024, at 4:54 pm. email correspondence with RNCNS-F indicated new	01940		

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01940	Continued From page 23 dressing change orders were highlighted and flagged for staff to review in the system independently. R1's services, and service reports lacked any wound care instructions, as a result there was no indication R1's current dressing change orders and instructions were visible to staff when the service was provided. The facility Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the facility provided basic and complex wound care. However, an email communication from RNCNS-F on June 21, 2024, at 1:46 p.m. indicated R1's wound care orders could not be accommodated due to service limitations of the licensee's UDALSA and indicated wound management and oversight responsibilities were deferred to R1's provider, home health agency, and wound care center who conducted weekly measurements. Documentation of the facilities monthly and ongoing wound monitoring and assessment were requested, none was provided. On June 10, 2024, at 12:04 p.m. when interviewed RNCNS-F stated she was aware R1 was only to be up for meals and indicated R1 was non-compliant with offloading in bed and repositioning every 2 hours until recently despite R1's record having no indication offloading was implemented by the facility as ordered by the provider. On June 21, 2024, at 1:46 p.m. email communication with RNCNS-F when asked about the LPN and RN supervision of delegated dressing changes to ULP staff on R1's service agreement, RNCNS-F indicated the LPN only provided the service for a short time, and indicated she was unable to provide a report to show RN supervision was provided.	01940		

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01940	Continued From page 24 On June 26, 2024, at 9:43 a.m. Homecare RN-J stated Homecare staff provided wound care and dressing changes 3 times per weekly and licensee staff were to provide R1's wound care and dressing changes when the Homecare nurses were not there. RN-J stated R1 had fecal matter in his wounds because wound care and dressing changes were not provided by licensee staff. RN-J stated R1 reported to Homecare nursing staff he had not been repositioned or offloaded as ordered, and licensee staff had only completed dressing changes 2 times in a month. RN-J stated Homecare nurses reported concerns of R1's dressing changes not being done to facility staff who stated they were not providing R1's wound care because they had not been trained. RN-J stated RNCNS-F was not involved in R1's wound care, wound assessment, or supervision of ULP staff delegated to provide wound care to R1, and indicated she wanted Homecare to take that reasonability On June 26, 2024, at 4:29 p.m. Homecare RN-K stated ULP staff were not completing R1's dressing changes as ordered. RN-K stated R1 was often found on numerous occasions with incontinent stool, no dressing in place, and fecal matter in R1's pressure ulcer wound beds. RN-K indicated she had reported the concerns to RNCNS-F who stated the licensee's ULP staff needed to be trained. On June 26, 2024, at 8:33 a.m. Homecare LPN-A stated she was seeing R1 twice weekly pressure ulcer wound care on his bottom. LPN-A stated on multiple occasions she observed no dressing in place, R1 was often incontinent of stool, and had fecal matter in the pressure ulcer wound beds. LPN-A indicated R1 had frequent	01940		

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01940	Continued From page 25 loose bowel movements and R1's pressure ulcers were near the rectum and prone to become soiled frequently. LPN-A stated R1's wound care orders indicated the dressings should be changed when soiled or dislodged, but those orders were not followed by the licensee staff. LPN-A stated R1 and multiple ULP staff had reported on numerous occasions R1's dressing changes were not being done because the facility had no supplies, and staff were not trained to provide wound care to R1. LPN-A stated she would left dressing supplies for staff, but they continued to not provide dressing changes to R1. LPN-A stated R1's pressure ulcer wounds progressively worsened. On June 27, 2024, at 12:38 p.m. Homecare RN-B stated she provided weekly dressing changes and wound monitoring for R1's pressure ulcers. RN-B stated the facility ULP staff were to provide dressing changes but it was not getting done, or was done incorrectly. RN-B stated R1 and ULP staff reported they were not trained to complete the dressing changes, and they had no supplies. RN-B stated R1's wounds often had no dressing, or no packing in the wound bed allowing fecal matter to enter the pressure ulcers. RN-B stated she would leave supplies for staff to complete dressing changes. RN-B stated RNCNS-F stated she was unable to provide wound care or dressing changes to R1, and indicated ULP staff were to provide R1's wound care. R1's outside medical record indicated prior to admission to the facility R1's wounds included an unstageable pressure ulcer with the wound onset date of January 16, 2024, (prior to admission to the facility) on R1's left ischial tuberosity, and a stage III coccyx pressure ulcer that was 65% healed. On March 26, 2024, R1's pressure ulcers	01940		

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01940	Continued From page 26 were both a stage III. On February 13, 2024, R1's orders indicated R1 should spend most of his time in bed with side-to-side repositioning and a minimal amount of time in his wheelchair. However, the record indicated R1 continued to repeatedly report to the provider he was spending a significant amount of time up in his wheelchair (4 to 8+ hours per day). In June R1's outside medical record indicated R1's wounds continued to deteriorate and had worsened to stage 4 non-healing pressure ulcers with undermining, and exposed bony structures present. In addition, an MRI completed at that time identified concerns of osteomyelitis (a severe bone infection). The facility policy titled "Initial and Ongoing Nursing Assessment of Resident's" reviewed January 3, 2023, indicated an RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs prior to admission if possible, on admission, 14 days after the start of services, and ongoing but not less than every 90 days. Section 3. indicated the assessment would include a review of records including physical and health status, current health conditions, and medical diagnoses. Section K. indicated a list of treatments to include the type, frequency, and level of assistance needed. Section L. Indicated nursing needs including potential to receive nursing delegated services would be identified. Section 4. indicated the RN would reassess on an ongoing basis, based on the resident needs, and with a change in condition. Section 4 d. indicated the RN would review the resident's service plan, evaluate the residents treatments, and update the service plan as necessary based on the resident's needs. The facility policy titled "Delegation of Nursing Tasks" reviewed February 13, 2023, indicated	01940		

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01940	Continued From page 27 nursing tasks would be appropriately delegated to unlicensed personnel using the licensed staff professional judgment. Section 1. indicated a RN may delegate nursing services if they had successfully completed training for the service to be provided and demonstrated the ability to competently follow the procedures and skills consistent with the complexity of the task. The delegation of treatments indicated the RN would develop and maintain a current individualized treatment record and instruct unlicensed staff in the proper methods to provide treatment or perform tasks and determine unlicensed personnel have demonstrated the ability to competently follow procedures. Section 5. indicated before delegating a task to unloosened staff each staff member would perform the task and had been instructed in the proper procedures. The RN would document each staff received this instruction and sign off to attest each staff had read and understood the instructions prior to providing the service. The RN will ensure training and competency records are kept up to date for all unlicensed staff and easily accessible to determine which staff are competent to perform various delegated tasks. Section 6. Indicated the RN would establish, implement, and update a system to communicate unlicensed staff and their competencies to determine the appropriateness of delegating tasks. Policies and procedures for wound care, wound assessment and monitoring, pressure ulcer assessment and monitoring, and implementation of providers orders were requested none were provided. No additional information was provided.	01940		

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01940	Continued From page 28 TIME PERIOD FOR CORRECTION: Seven (7) Days	01940		
02320 SS=J	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an accurate timely nursing assessment of the resident's needs including implementing ordered interventions to promote wound healing for 1 of 1 resident's (R1) admitted with pressure ulcers. In addition, the licensee failed to ensure unlicensed personnel (ULP) staff delegated to complete R1's wound care and dressing changes were trained and competent, and failed to provide ongoing wound assessment, monitoring, and supervision of delegated tasks. R1 was harmed when two pressure ulcers progressively worsened to stage 4 pressure ulcers with exposed bone. This practice resulted in a level four violation (a violation that results in 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).	02320		

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02320	Continued From page 29 Findings Include: R1 was admitted to the facility on January 25, 2024, with diagnoses including quadriplegia (paralysis of all 4 limbs) secondary to multiple sclerosis (a chronic disease damaging the myelin coating of nerves), type 2 diabetic, stroke, and left sided spastic hemiparesis (a condition causing involuntary muscle contractions). On January 25, 2024, the resident's admission service agreement included wound care completed by a Licensed Practical Nurse (LPN) weekly and indicated the Registered Nurse (RN) would complete monthly wound care supervision. The service plan failed to include daily wound care and dressing changes. On January 29, 2024, (4 days after admission) R1's faxed wound care orders to the facility included instruction for pressure ulcer wound care to be provided to R1's pressure ulcer wounds. The orders indicated the right ischial pressure ulcer was to have a thin layer of triad paste to the ulcer bed and peri wound area, covered by an ABD pad and secured with R1's brief. The orders indicated R1's left ischial ulcer was to have a thin layer of triad paste to the peri ulcer area, non-selective debridement using therahoney to the ulcer bed and instructed staff to apply therahoney to a 2 X 2 coarse gauze then tuck into the depth of the ulcer. The orders included instructions for staff to apply Vaseline to R1's coccyx ulcer, apply an ABD and secure with R1's brief. The orders indicated R1's dressings should be changed daily and as needed if soiled or loose. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of	02320		

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02320	Continued From page 30 less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be turned and repositioned every 2 hours and as needed (PRN). On February 5, 2024, R1's first admission assessment completed 11 days after R1 was admitted to the facility indicated R1 had a stage 4 pressure ulcers one on his right ischial tuberosity, and an unstageable wound on his coccyx area. The assessment indicated R1 required wet to dry dressing change twice daily (BID), and staff were to apply skin barrier cream to peri wound area, turning and reposition R1 every 2 hours with scheduled offloading times, and indicated R1 used a pressure relieving cushion in R1's wheelchair. The assessment failed to accurately identify R1's wound care/dressing change needs as ordered, and other interventions to reduce pressure, friction, shearing and promote wound healing. Two days later on February 7, 2024, R1's 14-day assessment was completed which indicated R1 only had one pressure ulcer on his coccyx area. The assessment failed to identify R1 required dressing changes and had no interventions for the treatment of R1's pressure ulcers injuries other than to provide pressure reduction measures to R1's buttocks. The assessment indicated skilled nursing would evaluate and treat R1's pressure wounds. The assessment failed to accurately identify R1's pressure ulcers, wound care/dressing change needs as ordered, and other interventions to reduce pressure, friction, shearing and promote wound healing. On February 13, 2024, R1's faxed wound care orders to the facility included instructions for R1's right ischial ulcer and all areas of breakdown on	02320		

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02320	Continued From page 31 R1's buttocks, apply a thin layer of triad paste to the ulcer bed and peri ulcer areas, then cover with an ABD and secure with R1's brief. For R1's left ischial ulcer and coccyx ulcers staff should apply a thin layer of triad paste to the peri ulcer area, non-selective debridement via course gauze slightly moistened with saline and gently tucked into the ulcer beds then covered with an ABD. The orders indicated R1's dressings should be changed daily and as needed (PRN) if soiled or loose. The orders indicated R1 should be in his bed and repositioned side to side every 2 hours, with R1 only be up in his wheelchair for 30-45 minutes at mealtimes only. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be turned and repositioned every 2 hours and as needed (PRN). On February 21, 2024, R1's faxed wound care orders to the facility remained unchanged from the February 13, 2024, orders. On March 8, 2024, R1's faxed wound care orders to the facility indicated R1's right ischial ulcer and all areas of breakdown on bilateral buttocks and scrotum should have Nystatin powder and cover with barrier cream. The orders instructed to apply PRN with brief changes to ensure skin stays clean and dry. The orders indicated the left ischial and coccyx ulcers should have a thin layer of calazime paste to the peri ulcer area, and instructed staff to tuck dry coarse gauze into the pressure ulcer wound bed, then cover with ABD. The orders indicated staff should change all R1's dressings daily and PRN if soiled or loose. The orders included instructions for staff to reduce	02320		

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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
02320	Continued From page 32 pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and PRN. The orders indicated R1 should be up in his chair for meal times only. On March 13, 2024, the resident's faxed wound care orders to the facility remained unchanged from the March 8, 2024, orders. On March 20, 2024, the resident's faxed wound care orders to the facility remained unchanged from the March 8, 2024, orders. On March 26, 2024, the resident's faxed wound care orders to the facility remained unchanged from the March 8, 2024, orders. On April 9, 2024, R1's faxed wound care orders to the facility included instruction to all areas of breakdown on bilateral buttocks and scrotum staff should apply a light layer of barrier cream, apply as needed (PRN) with brief changes to ensure skin stays clean and dry and indicated staff may alternate with A&D ointment or Vaseline if R1's skin became too dry. The orders indicated to R1's left ischial and coccyx pressure ulcers staff should apply a thin layer of calazime paste to R1's peri ulcer area and provide nonselective debridement via coarse gauze dampened with saline to the ulcer bed (2 X 2 gauze used in the coccyx ulcer), cover with ABD pad, secured with paper tape. The orders indicated R1's dressings should be changed twice daily and PRN if soiled or loose, and instructed staff to not scrub off the cream, and indicated if there was a layer present do not add more. The orders included instructions	02320		

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02320	Continued From page 33 for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and as needed (PRN). The orders indicated R1 should be up in his chair for mealtimes only. On April 16, 2024, R1's faxed wound care orders to the facility included instructions to all areas of irritation/redness on bilateral buttocks and scrotum staff should apply a mixture of triamcinolone cream and calazime. The orders instructed to apply the mixture daily with dressing changes to ensure skin stays clean and dry. To R1's left ischial and coccyx ulcers staff should apply a thin layer of the cream mixture to R1's peri ulcer areas. Provide debridement via Santyl, nickel thickness to wounds followed by coarse fluffed gauze to ulcer beds (2 X 2) used in the coccyx ulcer bed, cover with ABD and secure with paper tape. Wash off Santyl and reapply daily. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of the R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and as needed (PRN). The orders indicated R1 should be up in his chair for mealtimes only. On April 23, 2024, R1's faxed wound care orders to the facility included instructions to all areas of irritation apply a 50/50 mixture of Miconazole powder (nystatin) and calazime daily with dressing changes, and brief changes to ensure	02320		

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02320	Continued From page 34 skin stays clean and dry. To R1's left ischial and coccyx ulcer apply a layer of the mixture to peri ulcer areas, and provide debridement via Santyl, nickel thickness, followed by coarse fluff gauze (do not moisten) to ulcer beds (2 X 2 gauze to coccyx and left ischial) do not over pack. Cover with ABD and secure with brief, wash off Santyl and reapply daily. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under R1, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and as needed (PRN). The orders indicated R1 should be up in his chair for meal times only. On May, 6, 2024, a hospital readmission assessment identified R1 had pressure ulcers, and required dressing changes twice daily. R1 was up at 8:00 a.m. and in bed for 1 hour during the day, then went to bed around 9:45 p.m. The assessment indicated R1 required periodic repositioning for offloading every 2 hours while up in his chair. The readmission assessment indicated R1 required skilled nursing oversight with complex wound care dressing changes. The assessment failed to identify R1's wound care/dressing change needs as ordered, and other interventions to reduce pressure, friction, shearing and promote wound healing including, and failed to indicate R1 should be offloaded in bed and repositioned every 2 hours and PRN, with R1 up in his chair for mealtimes only. On May 7, 2024, R1's faxed wound care orders to the facility included instructions to apply the 50/50 mixture of miconazole and calazime to peri ulcer areas. Provide wound debridement via damp to	02320		

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02320	Continued From page 35 dry dressing using gauze and normal saline to wound beds. Apply course fluff gauze saline moistened to ulcer beds (2 X 2 gauze used in coccyx ulcer, and 4X4 gauze used in left ischial ulcer) do not over pack, cover with ABD. Change dressings daily and PRN if soiled or dislodged. The orders included instructions for staff to reduce pressure, friction, and shearing which included keeping the head of R1's bed equal of less than 30 degrees, protect the areas from the sling lift during transfers, limit linens and chux under the resident, and indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and PRN. The orders indicated R1 should be up in his chair for mealtimes only. R1 Service agreement dated April 1, 2024, indicated staff would provide wound care and dressing changes daily. The service agreement indicated repositioning was provided 12 times daily, and indicated an RN provided wound care supervision monthly, and dressing changes supervision 3 days a week, and an LPN would complete wound care 3 days a week. The service agreement failed to indicate wound care would be delegated and completed by unlicensed personnel (ULP) staff. The service plan failed to include interventions for staff to implement to reduce pressure, friction, and shearing, and failed to indicated R1 should be offloaded in bed with turning and repositioning provided every 2 hours and PRN, and only up in his chair for meal times. R1's care plan identified R1 had pressure ulcers and indicated staff should reposition the resident every 2 hours for offloading while he was up in his wheelchair. The care plan instructed staff to transfer the resident to bed mid-day. The care plan lacked instructions for physician ordered	02320		

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02320	Continued From page 36 interventions to reduce pressure, friction, and sheering including offloading R1 primarily in bed with repositioning side to side with R1 in his wheelchair for meals only. The care plan failed to indicate wound care was provided by the facility, had no wound care instructions included in the R1's plan of care for staff to implement, and indicated R1's wounds were managed by an outside agency. On June 21, 2024, at 1:46 p.m. email correspondence with RN Clinical Nurse Supervisor (RNCNS)-F indicated the licensee had no orders for wound care or dressing changes to be completed until 4 days after R1 was admitted to the facility with pressure ulcers. RNCNS-F indicated wound care completed in January and February was documented under a service titled "bed rail alert". R1's bed rail alert service delivery record was reviewed which included documentation of dressing changes completed by the facility from the day R1 was admitted on January 25, 2024, to February 13, 2024. The service included instructions to complete wound care orders as written (4 days before the facility had orders for dressing changes). The service record lacked specific direction to staff to include providers orders for wound care and instructions on how to complete R1's dressing changes. As a result, there is no way to know what wound care was provided to R1 by the facility. R1's service delivery record for wound dressing change services from March 2024, through June 2024, were reviewed and indicated the service was not initiated until March 15, 2024, indicating no wound care was provided to R1 as ordered from February 13, 2024, to March 15, 2024. The	02320		

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02320	Continued From page 37 service delivery record lacked specific direction to staff to include providers orders for wound care and instructions on how to complete R1's dressing changes. As a result, there is no way to know what wound care was provided to R1 by the facility. R1's service reports failed to indicate the licensee implemented ordered interventions for wound healing including offloading R1 primarily in bed with repositioning side to side every 2 hours, with a minimal amount of time up in his wheelchair. The service reports failed to indicate interventions to reduce pressure, friction, and sheering to promote wound healing were implemented by the licensee. Although R1's service plan indicated an RN provided monthly wound care supervision, and an LPN provided wound care dressing changes 3 days per week. The service record indicated the LPN's service was provided 6 of the 13 times scheduled in March 2024, 1 of 13 times in April 2024, and indicated the service was not provided in May or June 2024. The record lacked any documentation of an RN completing monthly wound care supervision. R1's progress notes were reviewed and lacked any documentation of the facility RN completing ongoing wound assessment, monitoring, or supervision of dressing changes delegated and completed by ULP staff. A facility provided document titled "wound notes" included some of R1's dressing change instructions from March 14, 2024, April 5, 2024, May 6, 2024, and May 7, 2024, the wound notes did not match the providers orders and instructions or include updates when the orders	02320		

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02320	Continued From page 38 changed. On June 26, 2024, at 4:54 pm. email correspondence with RNCNS-F indicated new dressing change orders were highlighted and flagged for staff to review in the system independently. R1's services, and service reports lacked any wound care instructions, as a result there was no indication R1's current dressing change orders and instructions were visible to staff when the service was provided. A review of 5 ULP staff training and competency records who documented providing wound care to R1 (6 months after R1 was admitted to the facility with wound care orders) showed some staff had generalized wound care training, but the documentation lacked any skills and competency specific to R1's providers orders to ensure R1's wound care dressing change needs were done correctly, and with each subsequent order change. The facility Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated the facility provided basic and complex wound care. However, an email communication from RNCNS-F on June 21, 2024, at 1:46 p.m. indicated R1's wound care orders could not be accommodated due to service limitations of the licensee's UDALSA and indicated wound management and oversight responsibilities were deferred to R1's provider, home health agency, and wound care center who conducted weekly measurements. Documentation of the facilities monthly and ongoing wound monitoring and assessment were requested, none was provided. R1's outside medical record indicated prior to admission to the facility R1's wounds included an unstageable pressure ulcer with the wound onset date of January 16, 2024, (prior to admission to	02320		

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02320	Continued From page 39 the facility) on R1's left ischial tuberosity, and a stage III coccyx pressure ulcer that was 65% healed. On March 26, 2024, R1's pressure ulcers were both a stage III. On February 13, 2024, R1's orders indicated R1 should spend most of his time in bed with side-to-side repositioning and a minimal amount of time in his wheelchair. However, the record indicated R1 continued to repeatedly report to the provider he was spending a significant amount of time up in his wheelchair (4 to 8+ hours per day). In June R1's outside medical record indicated R1's wounds continued to deteriorate and had worsened to stage 4 non-healing pressure ulcers with undermining, and exposed bony structures present. In addition, an MRI completed at that time identified concerns of osteomyelitis (a severe bone infection). On June 10, 2024, at 12:04 p.m. when interviewed RNCNS-F stated she was aware R1 was only to be up for meals and indicated R1 was non-compliant with offloading in bed and repositioning every 2 hours until recently despite R1 record having no indication offloading was implemented by the facility as ordered by the provider. Email communication with RNCNS-F on June 21, 2024, at 1:46 p.m. when asked about the LPN and RN supervision of delegated dressing changes to ULP staff on R1's service agreement, RNCNS-F indicated the LPN only provided the service for a short time, and indicated she was unable to provide a report to show RN supervision was provided. On June 26, 2024, at 9:43 a.m. Homecare RN-J stated Homecare staff provided wound care and dressing changes 3 times per weekly and licensee staff were to provide R1's wound care and dressing changes when the Homecare nurses were not there. RN-J stated R1 had fecal	02320		

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02320	Continued From page 40 matter in his wounds because wound care and dressing changes were not provided by licensee staff. RN-J stated R1 reported to Homecare nursing staff he had not been repositioned or offloaded as ordered, and licensee staff had only completed dressing changes 2 times in a month. RN-J stated Homecare nurses reported concerns of R1's dressing changes not being done to facility staff who stated they were not providing R1's wound care because they had not been trained. RN-J stated RNCNS-F was not involved in R1's wound care, wound assessment, or supervision of ULP staff delegated to provide wound care to R1, and indicated she wanted Homecare to take that reasonability. On June 26, 2024, at 4:29 p.m. Homecare RN-K stated ULP staff were not completing R1's dressing changes as ordered. RN-K stated R1 was often found on numerous occasions with incontinent stool, no dressing in place, and fecal matter in R1's pressure ulcer wound beds. RN-K indicated she had reported the concerns to RNCNS-F who stated the licensee's ULP staff needed to be trained. On June 26, 2024, at 8:33 a.m. Homecare LPN-A stated she was seeing R1 twice weekly pressure ulcer wound care on his bottom. LPN-A stated on multiple occasions she observed no dressing in place, R1 was often incontinent of stool, and had fecal matter in the pressure ulcer wound beds. LPN-A indicated R1 had frequent loose bowel movements and R1's pressure ulcers were near the rectum and prone to become soiled frequently. LPN-A stated R1's wound care orders indicated the dressings should be changed when soiled or dislodged, but those orders were not followed by the licensee staff. LPN-A stated R1 and multiple ULP staff had reported on	02320		

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02320	Continued From page 41 numerous occasions R1's dressing changes were not being done because the facility had no supplies, and staff were not trained to provide wound care to R1. LPN-A stated she would left dressing supplies for staff, but they continued to not provide dressing changes to R1. LPN-A stated R1's pressure ulcer wounds progressively worsened. On June 27, 2024, at 12:38 p.m. Homecare RN-B stated she provided weekly dressing changes and wound monitoring for R1's pressure ulcers. RN-B stated the facility ULP staff were to provide dressing changes but it was not getting done, or was done incorrectly. RN-B stated R1 and ULP staff reported they were not trained to complete the dressing changes, and they had no supplies. RN-B stated R1's wounds often had no dressing, or no packing in the wound bed allowing fecal matter to enter the pressure ulcers. RN-B stated she would leave supplies for staff to complete dressing changes. RN-B stated RNCNS-F stated she was unable to provide wound care or dressing changes to R1, and indicated ULP staff were to provide R1's wound care. The facility policy titled "Initial and Ongoing Nursing Assessment of Resident's" reviewed January 3, 2023, indicated an RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs prior to admission, if possible, on admission, 14 days after the start of services, and ongoing but not less than every 90 days. Section 3. indicated the assessment would include a review of records including physical and health status, current health conditions, and medical diagnoses. Section K. indicated a list of treatments to include the type, frequency, and level of assistance needed. Section L. Indicated nursing needs	02320		

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02320	Continued From page 42 including potential to receive nursing delegated services would be identified. Section 4. indicated the RN would reassess on an ongoing basis, based on the resident needs, and with a change in condition. Section 4 d. indicated the RN would review the resident's service plan, evaluate the resident's treatments, and update the service plan as necessary based on the resident's needs. The facility policy titled "Delegation of Nursing Tasks" reviewed February 13, 2023, indicated nursing tasks would be appropriately delegated to unlicensed personnel using the licensed staff professional judgment. Section 1. indicated a RN may delegate nursing services if they had successfully completed training for the service to be provided and demonstrated the ability to competently follow the procedures and skills consistent with the complexity of the task. The delegation of treatments indicated the RN would develop and maintain a current individualized treatment record and instruct unlicensed staff in the proper methods to provide treatment or perform tasks and determine unlicensed personnel have demonstrated the ability to competently follow procedures. Section 5. indicated before delegating a task to unloosened staff each staff member would perform the task and had been instructed in the proper procedures. The RN would document each staff received this instruction and sign off to attest each staff had read and understood the instructions prior to providing the service. The RN will ensure training and competency records are kept up to date for all unlicensed staff and easily accessible to determine which staff are competent to perform various delegated tasks. Section 6. Indicated the RN would establish, implement, and update a system to communicate unlicensed staff and their competencies to	02320		

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02320	Continued From page 43 determine the appropriateness of delegating tasks. Policies and procedures for wound care, wound assessment and monitoring, pressure ulcer assessment and monitoring, and implementation of providers orders were requested none were provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	02320		
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: Based on interview and document review, the facility failed to ensure one of one of one residents 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		

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02360	Continued From page 44 No plan of correction is required for this tag.	02360		