STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245452	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Episcopal Church Home of Minnesota	1879 Feronia Avenue Saint Paul, MN 55104

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to notify the resident's representative with a change to a resident's health when a new medication and treatment were ordered for 1 of 3 resident reviewed. R1 was identified as having a wound on his right leg and the facility notified the provider, obtained an order for an antibiotic, and a dressing change. The change and treatment were initiated without informing the resident representative. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's progress note dated 5/6/24 11:38 a.m. indicated a call was placed to R1's Primary Care Physician (PCP) regarding his right leg having a lots of drainage from two big patches on the right outer aspect. In addition, a urine culture >100,000 colonies were called and faxed to the Primary Care Provider (PCP). R1's progress note dated 5/6/24 indicated R1 was ordered Macrobid (antibiotic) 100 milligram (mg) by mouth twice daily for weeping blisters on R1's right leg until 5/14/24. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to his right leg, was to wash area daily with mild soap and pat dry. Okay to cover with Mepilex (a dressing which covers and secures wounds) if draining, allow the fluid to drain, if significant drainage then cover with an ABD pad (a pad used for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per their recommendations and for Plastic Surgery was to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 8:06 a.m. family member (FM)-A stated she became aware that R1 had a wound at his care conference on 5/14/24. The reason she was told at that point about the wound was to consent to R1 seeing the wound care team for treatment. She stated that as a nurse she was aware that the facility had noticed a wound and did not report that to her. She stated she spoke with the R1's nurse practitioner (NP) who saw R1 and was told that the NP was notified of a wound on 5/6/24 and provided orders of Macrobid 100 mg twice daily and a dressing change. FM-A stated R1 was found to have wounds on both legs, both his heels and his buttock when he arrived at the hospital. FM-A stated if she had been informed when the wound had first identified her, and her sister would have monitored the wound when they visited R1 and that maybe could have prevented the hospitalization if they had eyes on him as well. FM-A stated she is the Power of Attorney (POA) for R1, and the facility is aware that she makes the decision for R1. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing (ADON) stated he could not produce any documentation that R1's representative was notified prior the care conference on 5/14/24 when she was asked to give consent for the wound nurse to treat R1. He stated FM-A was the POA and the decision maker for R1. A facility policy titled Change in Condition with a revised date of 5/4/22 indicated the facility shall promptly notify their attending Medical Doctor, and the elder's power of attorney, substitute decision maker or other person as indicated by the resident of changes in the resident's condition.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to report an allegation of neglect immediately, but not later than two hours, to the State Agency (SA) for 1 of 1 resident (R1) reviewed for skin integrity when the hospital contacted the facility when R1 was admitted for wound care that required surgical intervention and three pressure ulcers were found. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to right leg, was to wash area daily with mild soap and pat dry. Ok to cover with Mepilex if draining, allow the fluid to drain, if significant drainage then cover with an ABD pad (a pad used for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. R1's progress note dated 5/13/24 at 11:28 a.m. indicated R1's nurse practitioner (NP) looked at R1's wounds and recommended the wound care team to evaluate and treat the bilateral lower extremity wounds, due to likely needing debridement due to slough and eschar (dead tissue). The NP placed an order to send R1 to the hospital on 5/17/24 following a visit from the wound care team. Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. Hospital history and physical dated 5/17/24 indicated R1 presented from his nursing home for evaluation of lower extremity wounds. Per report, he has had wounds on his legs for about a month. Unclear how these occurred. He had local wound at the facility, but the patient's physician requested evaluation at the hospital. R1 had an extensive necrotic wound on the posterolateral right lower extremity and smaller necrotic wound on posterior left lower extremity. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. R1 was started on intravenous Vancomycin (broad spectrum antibiotic). R1 had blood cultures in process and a consultation was ordered for General Surgery and Plastic Surgery. R1 arrived from the emergency department with an ABD pat wrapped in kerlix on his right lower extremity saturated, which was changed. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots applied to both feet. General Surgery Consultation Plan dated 5/17/24 indicated R1 would likely need debridement of the wounds in the operating room. Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated wounds: -Wound #1 was on the right lateral posterior lower leg. The wound was full thickness, the base was 90% dry adherent, brown eschar, 10% white moist slough. The peri wound: denuded (loss of epidermis) and erythema (redness) measurements were length (L) 17 centimeters (cm) x width (W) 12 cm x depth (D) 0.5 cm. The drainage amount was small. -Wound #2 left posterior lower leg with an unknown etiology, full thickness. The wound base was 100% necrotic tissue-black, adherent eschar, demarcation at the wound edge with purulent drainage. The peri wound area had erythema with a small amount of drainage, the drainage was purulent, malodorous the wound had moderate odor. -Wound #3 location was the right buttocks, a pressure injury - community acquired. The base was 100% non-blanchable tissue. The peri wound was intact. There was no drainage. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per their recommendations and for Plastic Surgery to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 2:39 p.m. the social worker (SW)-A stated the facility did not report the incident. She stated through her contact with the hospital and the family she was aware that the incident had been reported to the state agency for neglect on the facility. SW-A stated the facility became aware of the severity of the leg wounds and the addition of the pressure ulcer on 5/20/24 when the hospital was called about an updated status. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing deferred any questions about reporting the wounds stating the director of nursing (DON) was on vacation during the survey and he does report for the facility. He stated he was part of the facility investigation. Upon interview on 5/29/24 at 1:55 p.m. the Administrator stated he became aware that the facility received an update that a resident was in the hospital with wounds on 5/20/24. He stated he sat down with the DON and the SW to discuss the seriousness. It was decided the wounds were not in a location where it was caused by laying bed or kept wet. The Medical Director did not offer any concerns when the facility reached out to him. The facility had started to write-up an education plan for the staff following the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy on reporting was not obtained.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review, the facility failed to develop a care plan to address a significant change to skin integrity with wound treatment interventions for 1 of 3 residents (R1) reviewed. In addition, R1 was using a mechanical lift for transfers and a wheelchair for ambulation and the care plan indicated R1 transferred with the assistance of one staff member. Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals or interventions for potential skin integrity concerns or actual focus, goals, or interventions when a wound was discovered on 5/1/24. R1's care plan dated 8/15/23 indicated R1 required one staff member to move between surfaces. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to right leg, was to wash area daily with mild soap and pat dry. Ok to cover with Mepilex if draining, allow the fluid to drain, if significant drainage then cover with ABD pad (pad for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. R1's progress note dated 5/12/24 at 2:07 p.m. indicated R1's dressing was changed to bilateral (both legs) low extremities as ordered, dressing was soaked with fluids and had a foul smell to it. The blisters were open, and the wounds had some black and dark yellowish coverings all over. R1's progress note dated 5/13/24 at 11:28 a.m. indicated R1's nurse practitioner (NP) looked at R1's wounds and recommended the wound care team to evaluate and treat the bilateral lower extremity wounds, due to likely needing debridement due to slough and eschar (dead tissue). R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left antecubital and his buttocks. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 5/28/24 at 8:06 a.m. R1's family member (FM)-A stated she became aware that R1 had a wound at his care conference on 5/14/24. She asked for a copy of R1' care plan following the conference because she wanted to see when the wound care was initiated and what the treatment. She stated there was wound treatment plan or wound preventative measures on the R1's care plan. The care plan did not have directions for staff regarding the use of a mechanical lift with R1. Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he was aware that R1 required nursing to do a dressing change daily on his right leg. He stated around the week of 5/6/24 R1 was in his bed more than usual and the staff used an EZ-stand mechanical lift to get him up and a wheelchair for ambulation around the unit and prior R1 self-transferred and wandered most of the day by walking. NA-A felt the reason for his decline was either the wound on his heels or that he was having pain from a few recent falls of time. Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated she completed the skin audit on R1 on 5/1/24. He had so many bruises, but then she noticed a wound on his right lower extremity, describing the wound as very pink, no drainage and larger than a quarter. RN-A worked with R1 again on 5/15/24 and completed a skin audit. She stated on 5/15/24 R1 was too weak for a shower so the nursing assistant completed a bed bath, and the staff were using a mechanical lift to transfer R1 to his wheelchair and staff were required to assist R1 with mobility in the wheelchair. Upon interview on 5/29/24 at 1:47 the ADON stated any skin integrity concerns should be on the resident's care plan. The ADON was not aware that R1 declined from ambulating to requiring assistance with transfers and using a wheelchair. He stated the nurses can make that decision, but he is the one who updated the care plans. He confirmed that the skin integrity concerns, and the EZ-stand use were not on the care plan. A facility Policy titled Skin Care dated 1/2015 indicated each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care related to skin care. No other care plan related policies were obtained.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to ensure treatment, monitoring, and care in accordance with professional standards of practice were provided for 1 of 3 residents (R1) reviewed when skin ulcerations developed. R1's primary physician was not immediately notified when the first wound was discovered or when the wound had a significant change. R1 was admitted to the hospital with wounds on both legs requiring surgical interventions. The facility was only aware of the wound on R1's right leg. Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals or interventions for potential skin integrity concerns or actual focus, goals, or interventions when a wound was discovered on 5/1/24. R1's nursing assistant skin monitoring documentation dated 4/29/24-5/28/24 indicated on 4/30/24, 5/1/24, 5/2/24, 5/5/24, 5/8/24, and 5/10/24 R1 had a skin tear. The audit did not provide any other information regarding a skin tear documented. In addition, the form indicated on 5/10/24, 5/14/24 and 5/15/24 R1 had an open area. The audit did not provide any other information regarding the open area. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's weekly skin body audit dated 5/1/24 at 1:45 p.m. indicated a skin deficit was noted. The form indicated for the nurse to describe the deficiency and to call the wound nurse if the finding was the first occurrence. The audit indicated R1 had bruising to the right and left antecubital (area around the elbows), lower back, buttock, right and left lower leg bruising and a wound on the right lower leg. The columns for length, width and depth measurements were left blank. A note indicated bruises were noted all over R1's body and dry wound on his right low leg, cleaned and covered with Mepilex. R1's progress note dated 5/6/24 11:38 a.m. indicated a call was placed to R1's triage regarding right leg having a lots of drainage from two big patches on the right outer aspect. In addition, a urine culture >100,000 colonies were called and faxed to the Primary Care Provider (PCP). R1's progress note dated 5/6/24 indicated R1 was ordered Macrobid (antibiotic) 100 milligram (mg) by mouth twice daily for weeping blisters on R1's right leg until 5/14/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R1's physician order sheet dated 5/7/24 indicated treatment for R1's blisters to right leg, was to wash area daily with mild soap and pat dry. Ok to cover with Mepilex (a dressing to cover wounds to secure an prevent movement of the primary dressing) if draining, allow the fluid to drain, if significant drainage then cover with ABD pad (a pad for heavy drainage) and wrap with Kerlix and secure until resolution, update if area around blister/blisters itself starts to look inflamed, surrounding tissue becomes hot to the touch, and/or drainage becomes purulent (pus), bloody or otherwise appears infected. R1's list of weekly skin body audits did not show any documentation of a body audit completed on 5/8/14. R1's progress note dated 5/12/24 at 2:07 p.m. indicated R1's dressing was changed to bilateral (both legs) low extremities as ordered, dressing was soaked with fluids and had a foul smell to it. The blisters were open, and the wounds had some black and dark yellowish coverings all over. R1's progress note dated 5/12/24 at 2:17 p.m. indicated a voicemail was for the nurse manager, also the assistant director of nursing (ADON) to follow-up with the wound doctor. R1's progress note dated 5/13/24 at 11:28 a.m. indicated R1's nurse practitioner (NP) looked at R1's wounds and recommended the wound care team to evaluate and treat the bilateral lower extremity wounds, due to likely needing debridement due to slough and eschar (dead tissue). R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left antecubital and his buttocks. R1 had a wound to the rear of his right lower leg and a wound to the right ankle on the outer side. The length, width and depth measurements were left blank. A note indicated the dressing was changed on the right lower leg and ankle. The old dressing was soaked with drainage. Emergency Department note dated 5/16/24 at 5:54 p.m. indicated R1 had a large ulceration that was necrotic (dead tissue) appearing on his right posterior calf and a small ulceration over his right posterior heel. He also had a necrotic wound appearing on his left posterior calf. Hospital history and physical dated 5/17/24 indicated R1 presented from his nursing home for evaluation of lower extremity wounds. Per report, he has had wounds on his legs for about a month. Unclear how these occurred. Apparently, he had local wound at the facility, but the patient's physician requested evaluation at the hospital. R1 had an extensive necrotic wound on the posterolateral right lower extremity and smaller necrotic wound on posterior left lower extremity. Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. R1 was started on intravenous Vancomycin (broad spectrum antibiotic). R1 had blood cultures in process and a consultation was ordered for General Surgery and Plastic Surgery. R1 arrived from the emergency department with an ABD pat wrapped in kerlix on his right lower extremity saturated, which was changed. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots were applied to both of his feet. General Surgery Consultation Plan dated 5/17/24 indicated R1 would likely need debridement of the wounds in the operating room. R1's Power of Attorney (POA) was called and decided to hold surgery in an attempt for wounds to heal on their own. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated wound #1 was on the right lateral posterior lower leg. The wound was full thickness, the base was 90% dry adherent, brown eschar, 10% white moist slough. The peri wound: denuded (loss of epidermis) and erythema (redness) measurements were length (L) 17 centimeters (cm) x width (W) 12 cm x depth (D) 0.5 cm. the drainage amount was small. Wound #2 left posterior lower leg with an unknown etiology, full thickness. The wound base was 100% necrotic tissue-black, adherent eschar, demarcation at the wound edge with purulent drainage. The periwound area had erythema with a small amount of drainage, the drainage was purulent, malodorous the wound had moderate odor. Plastic surgery consultation note dated 5/16/24 indicated dressing changes were going to be ordered for both lower extremities and in the next 24-48 hours discuss appropriately of wound vacuum assistance therapy (VAC) therapy. R1 would benefit from skin grafting given the size of the wounds. Surgical note dated 5/20/24 family gave verbal consent for debridement of the bilateral lower extremity wounds via surgical procedure. General Surgery Post-Operative Progress note dated 5/21/24 at 10:29 a.m. indicated R1 had excisional debridement of bilateral lower extremity wounds. Tissue culture was growing gram positive-cocci and gram-negative bacilli. Post-surgical plan for wound care was to re-consult regarding ongoing wound recommendations, continue wound cares per their recommendations and for Plastic Surgery to be involved regarding future inventions with the wound depending on the POA's decisions. Upon interview on 5/28/24 at 8:06 a.m. family member (FM)-A stated she became aware that R1 had a wound at his care conference on 5/14/24. The reason she was told at that point about the wound was to consent to R1 seeing the wound care team. She stated that as a nurse she was aware that the facility had noticed a wound and did not report that to her. She stated she spoke with the care team who saw R1 and was told that they were notified of a wound on 5/6/24 and provided orders of Macrobid 100 mg twice daily and a dressing change. FM-A stated R1 was found to have wounds on both legs, both his heels and his buttock when he arrived at the hospital. I wish I wouldn't have looked at the photos, they disgust and sadden me at the same time. This was a sentinel event. She stated making decisions for R1 were difficult due to his age, mental status, kidney function and diabetes, but decided on a surgical intervention. Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he was aware that R1 required nursing to do a daily dressing change on R1's right leg. He stated the wound would weep through the dressing at least once during his shift so he would ask the nurses rechange the dressing and he would have to change R1's clothing and sometimes his bed. (continued on next page)

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	245452	A. Building B. Wing	05/29/2024

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 5/28/24 at 1:29 p.m. R1's Nurse Practitioner (NP) stated the first she knew of a wound the was on 5/6/24 at 11:07 a.m. when she received a page about urinalysis results and that R1 had skin integrity issues. The skin issues were described as a new blister on his right lower leg with no edema, clear drainage, no redness or swelling. She stated she ordered Macrobid 100 mg twice a day and a daily dressing change. She stated she did round the facility every Monday and on 5/13/24 with the same nurse who sent her a message on 5/6/24 who asked her to see R1 as he had concerns about the wound. The NP stated she saw both legs were wrapped in Kerlix. She was unaware of any concerns with R1's left leg. The nurse unwrapped both legs and on the right anterior leg below the knee to the ankle was fully sloughed. She could not see any depth to the wound. She stated the left leg appeared the same, but not as large. She asked the nurse When did this start? licensed practical nurse (LPN)-A responded, last week when I paged you, The NP stated he needs debridement on his legs due a wound, this was not a blister. She lifted his legs to look at his heels and ordered wound care for his heels bilaterally for the pressure ulcers. The NP messaged the ADON to order wound care as soon as possible. She stated it was not until 5/16/24 that the wound nurse visited R1 and reached out to the NP because R1's right leg was necrotic, and he required hospitalization . The NP wrote an order to send R1 to the hospital immediately. The NP stated from 5/6/24 until 5/13/24 R1 had an acute change of the right leg and the addition of a wound to the left leg, and they were not reported to her. She stated if she were notified earlier instead of waiting until she rounded, she could have ordered wound care earlier. The NP stated she was also not aware that R1 had declined. Upon interview on 5/28/24 at 2:15 p.m. LPN-A stated he worked on the dementia unit once a week. On 5/6/24 he noticed R1 had his right leg wrapped with saturated Kerlix. He removed the dressing and noticed a blistered he described as about the size of a quarter. He looked for an order to see if he were to administer a treatment and was unable to find one. He notified the NP to get orders. He stated he did not work on the dementia unit again until the following Monday 5/13/24 and R1 was using his wheelchair. He had staff use the EZ-stand to lay R1 down in bed so he could complete his dressing change treatment. He stated he pulled off saturated dressing from both of R1's lower extremities and the wound on the right leg was from R1's knee to his foot and now there was a black wound on his left lower extremity. He knew the NP was onsite so he got her, so she could visualize the wounds. He stated she ordered the wound care team immediately, stating R1 needed debridement. Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated she completed the skin audit on R1 5/1/24. He had so many bruises, but then she noticed a wound on his right lower extremity, describing the wound as very pink, no drainage and larger than a quarter. She cleaned the wound and covered it with Kerlix. She denied obtaining wound measurements or notifying the provider of the change to his skin integrity. RN-A worked with R1 again on 5/15/24 and completed a skin audit. She stated on 5/15/24 R1 was too weak for a shower so the nursing assistant completed a bed bath. When RN-A observed the skin, she stated the wound was now totally different, it was on the back of his right leg and from his knee to his foot and half of the wound was red and the other half of the wound was white. RN-A immediately called the ADON and asked if he was aware of R1's wound as it was large and new to her. The ADON told her that the wound nurse would see R1 soon. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 5/29/24 at 10:09 a.m. a hospital registered wound nurse (RN)-B stated she completed R1's initial wound assessment at the hospital on 5/19. She stated he had significant infected wounds on both legs that required surgical intervention to remove necrotic tissue. She stated she was uncertain of the etiology of the leg wounds. She stated to prevent the wounds from getting to the level that they did she believed routine skin assessments were not performed because the state the wounds were in didn't happen overnight. The facility should have contacted the wound nurse or PCP for the infection sooner than they did. Upon interview on 5/29/24 at 11:20 a.m. NA-B stated she recalled R1 having a wound on his right leg. She stated she noticed a small circular red area before the nurses started wrapping R1's legs because she put compression hose on R1 in the mornings. She stated then his leg became swollen and drainage the staff stopped putting the compression hose on him, which she believed was around the end of 4/2024. Upon interview on 5/29/24 the Medical Director stated after he reviewed R1's records and interviewed the family and a few staff members he felt that R1's situation was a communication issue. He stated he believed that at times nursing staff does not want to tell a provider You need to come in and evaluate. He stated he also believed the facility was not aware of how long it would take the wound team to start the cares. The order was placed on 5/13/24 and the wound care nurse did not evaluate until 5/16/24. He stated on his record review he believed the wound started on 5/1/24, and orders were started on 5/6/24, but then a skin audit was missed on 5/8/24 and then not again until 5/15/24. The director stated he had not spoken with the NP or the PCP, however he would want to discuss the choice of antibiotic treatment and that they did not visualize the wound. He stated the NP or the PCP only see's patient's every 60 days and rely on the facility staff for all concerns in between and that is where the communication needs improvement. If the residents need to be seen more often the staff needs to complete their assessments and be reaching out to the providers. We should have stepped on the gas sooner with his wounds. R1 had a lot of acute issues, and he was a DNR/DNI with comfort cares and since R1 was not complaining of pain, the facility could have felt like they were meeting his needs. I still am doing a root cause analysis. The facility needs consistent staff on that unit, however that is a concern in all facilities of not having consistent staff. This will be worked on at QAPI. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Upon interview on 5/29/24 at 1:47 the ADON stated any skin integrity concerns should be reported when it first arises. He believed 5/1/24 was the date the wound could have started with a fall that R1 had, he denied ability to find any documentation on R1's fall incident reports that indicated any injury to the lower extremities. He stated when staff finds a weeping wound, they are to clean it and cover it until they receive treatment orders from the provider. The ADON stated he was aware that there was a wound with drainage on R1's right leg on 5/4/24 or 5/5/24 the weekend before the nurse reported the wound to the NP. The ADON stated he expects staff to obtain the required information on the skin audits so the wound status can be tracked. The ADON received a call on 5/12/24 which was a Sunday about the wound worsening, so the facility waited until 5/13/24 a Monday when the NP was onsite to show her the wound. The ADON denied assessing the wound at any time since 5/1/24 and did not visualize the wound until the wound nurse saw R1 on 5/16/24 requesting he be sent to the hospital. The ADON stated he did not notice the wound on R1's left leg. The ADON was not aware that R1 declined from ambulating to requiring assistance with transfers and using a wheelchair. He stated the nurses can make those decisions about using a lift or not, but he is the one who updated the care plans and denied that the skin integrity concerns, and the EZ-stand use were on the care plan. The ADON stated there are a lot of nurses who work on the dementia unit and as he was investigating R1's concerns he noticed seven different nurses working in the past seven days. A facility Policy titled Skin Care dated 1/2015 indicated each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care related to skin care.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to prevent three pressure ulcers for 1 of 3 residents (R1) reviewed for skin integrity. R1 was harmed when he developed three pressure ulcers that went without treatment, staff were aware but did not implement a treatment plan. The hospital identified the pressure ulcers when R1 was admitted for wound care and subsequent surgical debridement. Findings include: R1's care plan dated 10/28/23 - 5/28/24 did not indicate any focus, goals, or interventions for potential or actual skin integrity concerns when three pressure ulcers were discovered on 5/16/24 during a hospital admission. R1's quarterly Minimum Data Set (MDS) dated [DATE] indicated R1 had a Brief Inventory of Mental Status (BIMS) score of 10 indicating R1 was cognitively impaired. R1 required moderate assistance with toileting and transfer activities. He required maximum assistance with dressing and grooming. R1 was ambulatory with the use of a walker. R1's diagnoses were chronic atrial fibrillation (cardiac arrhythmia), anemia, hypertension (high blood pressure), renal (kidney) failure, diabetes type II, Non-Alzheimer's Dementia, long term use of anticoagulants (blood thinners) and edema. The MDS indicated R1 was at risk for pressure ulcers but did not have any pressure ulcers or wounds. R1 had a pressure reducing device on his bed. R1's weekly skin body audit dated 5/1/24 at 1:45 p.m. indicated a skin deficit was noted. The audit indicated R1 had bruising to the right and left antecubital (area around the elbows), lower back, buttock, right and left lower leg bruising and a wound on the right lower leg. The audit does not note any pressure ulcers. R1's list of weekly skin body audits did not show any documentation of a body audit completed on 5/8/14. R1's weekly skin body audit dated 5/15/24 indicated R1 had bruising of the right and left antecubital and his buttocks. R1 had a wound to the rear of his right lower leg and a wound to the right ankle on the outer side. The audit does not note any pressure ulcers. Hospital Emergency department review of systems note dated 5/16/24 indicated R1 had a large ulceration that was necrotic appearing on his right posterior calf and a small ulceration over his right posterior heel. Hospital assessment and plan dated 5/17/24 indicated the principal problem was a necrotic right leg wound. He would be inpatient for extensive right lower leg wound and smaller necrotic left lower leg wound. Mepilexes were applied to several wounds on his bilateral lower extremities including his heels. Aflex (protective) boots applied to both feet. Hospital Wound Initial Assessment Note dated 5/19/24 at 12:49 p.m. indicated R1 had three a pressure injury that were acquired in the nursing facility. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Pressure ulcer to right buttock. The base was 100% non-blanchable tissue. The peri-wound (skin surround the wound) was intact. There was no drainage. -Pressure ulcer to left heel. The wound base was 100% red moist tissue. The peri-wound had loss of epidermis. The measurements were length (L) 3 centimeters (cm) x width (W) 3 cm x depth (D) 0.2 cm. The heel pressure ulcer had a small amount of blood drainage with no odor. -Pressure ulcer to the right heel. The wound was full thickness (damage extends below all layers or skin in the subcutaneous tissue or beyond into the muscle, bone, tendons, etc.) The wound base was 100% grey, with slough. The peri-wound had loss of epidermis. The wound measured L 4 cm. x W 3.5 cm and D 0.3 cm with a small amount of drainage, a mild odor and mild pain. The wound was unstageable (the wound was covered by a layer of dead tissue and the doctor cannot see the base of the wound). Upon interview on 5/28/24 at 11:11 a.m. registered nurse (RN)-E a hospital wound nurse described R1's pressure ulcer as: The right buttock pressure ulcer was a shallow Stage II (broken through the top layer or skin). The right heel pressure ulcer was unstageable due to the dead tissue covering the wound. The left heel pressure ulcer was a Stage III (exposed muscle and subcutaneous fat). Upon interview on 5/28/24 at 11:32 a.m. nursing assistant (NA)-A stated he did not notice a pressure ulcer to R1's buttock, but the area was red, and he would apply barrier cream when he worked. He stated R1 around the week of 5/6/24 was in his bed more than usual and the staff used an EZ-stand mechanical lift to get him up and a wheelchair for ambulation around the unit. Prior to this R1 self-transferred and wandered most of the day by walking. NA-A felt the reason for his decline was either the wound on his heels or that he was having pain from a few recent falls. NA-A stated he did not report to a nurse about the heel sores that he just knew to float the heels while R1 was in bed and turn and reposition him if he was to remain in bed for long periods of time. NA-A described the heel wounds as redness and the top layer of skin missing. Upon interview on 5/29/24 at 9:51 a.m. registered nurse (RN)-A stated the skin audit on 5/15/24 R1's right heel had a white covered area over the heel. She denied documenting a wound description or measurements. Upon interview on 5/29/24 at 11:20 a.m. nursing assistant (NA)-B stated a few days before R1 was sent to the hospital she noticed the skin on R1's right heel was gone, and she did notify the nurse but could not recall which nurse. She stated R1 stopped ambulating about a week before he was sent to the hospital. It was when he was bedridden she noticed the right heel pressure injury. Upon interview on 5/29/24 at 1:47 p.m. the assistant director of nursing (ADON) sated he was of the pressure ulcers to R1's buttock or bilateral heels. Upon interview on 5/29/25 at 1:55 p.m. the Administrator stated he was not aware R1 had wounds until 5/20/24 when he received an update from the hospital. He stated the facility made a plan to educate staff on wounds. The director of nursing (DON) was on the vacation during the survey and the education would be completed upon her return. A facility protocol titled Wound care protocol indicated to prevent wounds the staff was do daily skin inspection. If a Stage I, II, or III wound was identified to notify the physician and obtain orders and a diagnosis.