STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. Building B. Wing	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester East Health Services	501 Eighth Avenue Southeast Rochester, MN 55904

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40946 Based on observation, interview and document review, the facility failed to comprehensively assess, revise care plan interventions following MD ordered interventions, and did not communicate timely with the medical doctor (MD) that a pressure ulcer (PU) was necrotic (tissue death). Facility staff waited two days after discovering the necrotic wound to request the MD come to the facility and assess resident. This resulted in an immediate Jeopardy (IJ) for R1 who was hospitilized and required three surgeries to treat the PU. The IJ began on 2/15/22, when the facility failed to timely intervene with medical services after discovering R1 had necrotic tissue. This had the possibility of further wound necrosis and increased pain. The director of nursing was notified of the IJ on 3/8/22, at 5:45 p.m. and the immediacy was removed on 3/9/22, at 1:45 p.m. when the facility's approved removal plan was verified onsite by the state agency but the noncompliance remained at the lower scope and severity level of D - no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1 was admitted to the facility on [DATE], with diagnoses including acute pancreatitis without necrosis or infection (inflammation of the pancreas), muscle weakness, Stage 3 chronic kidney disease (kidney failure), dementia without behavioral disturbance, atherosclerosis of native arteries of extremities with intermittent claudication (narrowing and hardening of the arteries that supply blood to the legs and feet), intracardiac thrombosis (blood clot in the heart), and thrombocytosis (excessive number of platelets in the blood that can lead to blood clots). R1's admission minimum data set (MDS) assessment dated [DATE], documented R1's Brief Interview of Mental Status (BIMS) assessment as R1 was moderately cognitively intact; R1's activities of daily living assessment identified R1 required extensive assistance with bed mobility, transferring, dressing, toileting and personal hygiene, and total dependence with locomotion; and skin assessment documented R1 did not have skin issues or a pressure ulcer upon admission. Review of R1's care plan copied 3/7/22, identified R1 at risk for skin integrity condition or pressure sores related to impaired mobility and incontinence. The goal of the intervention was to assess skin for redness or pressure related changes with each care encounter and report any changes immediately. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's Braden Scale for Predicting Pressure Sore Risk Scale dated 12/03/21, indicated R1 was at moderate risk of developing a pressure ulcer. Review of R1's Non-Pressure Weekly Tracker assessment dated [DATE], documented R1 had a facility acquired wound to his left buttocks. Review of the Weekly Pressure Wound Evaluations: 1/18/22 Measurements: Length 3.6 c.m. x width 1.8 c.m. x depth 0.1 c.m. 1/25/22 Measurements: Length 3.2 c.m. x width 1.5 c.m. x depth 0.1 c.m. 2/1/22 Measurements: Length 3.0 c.m. x width 1.0 c.m. x depth 0.1 c.m. 2/8/22 Measurements: Length 3.0 c.m. x width 1.1 c.m. x depth 0.1 c.m. Review of NP-A encounter visit summary dated 1/7/22, at 3:40 p.m. documented R1's sacral wound assessment. Documentation included, PU of right buttock Stage 1 measuring 2.5 x 1.0 cm, skin remains intact, non-blanchable, and facility staff to assess skin underneath dressing daily, and notify provider if skin breakdown is observed. PU of sacral region Stage 3, more on the left side, measures approximately 3.5 x 2 cm., and wound bed is covered with slough/fatty tissue. NP-A ordered to cleanse the right buttock and apply foam board dressing, and sacral region to apply Medihoney, change dressing daily, and cover with foam border dressing. Review of medical doctor (MD)-A encounter visit summary dated 1/11/22, unknown time of encounter, documented PU of sacral region Stage 3, measures approximately 3.5 x 2.0 cm., wound bed is covered with slough, cleanse the wound with normal saline or wound cleanser, pat dry, apply Medihoney, cover with foam border dressing, change dressing daily and as needed and to reposition resident every two hours to offload pressure. Review of NP-A encounter visit summary dated 2/7/22, 10:00 a.m. documented R1's sacral pressure ulcer is getting worse, updated wound measurements of 3.0 x 1.1 x 0.1 cm., and continue with previous treatment orders. No new pressure ulcer prevention interventions were added to R1 provider order. Review of medical and treatment records lacked evidence pressure ulcer interventions were included or added following the MD orders and that even though the PU was worsening, interventions were updated on the care plan since 12/7/21. Review of NP-A's Progress Note dated 2/7/22, at 10:00 a.m. directed to change to a air altering mattress, dietician to evaluate and treat (needs protein supplementation to help with wound healing), continue to work with physical therapy and occupational therapy, encourage R1 to frequently reposition himself every 1.5- 2 hours, and avoid forty-five degree angle in supine position except when eating. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Situation, Background, Assessment, Recommendation (SBAR) dated 2/15/22, at 2:29 p.m. created by registered nurse (RN)-A documented R1 has had a change in condition regarding the sacral wound that is currently being treated and has had significant changes over the last week. Resident's sacral area now has an open area of 2.3 x 1.0 x 0.6 c.m. and the area around the wound measures 7.0 x 6.2 c.m. of dark brown/black skin. There is odor coming from this area and it is notable when entering the resident's room. RN-A indicated R1 was to be followed up with nurse practitioner (NP)-A the following week, but with the significant changes this week, R1 should be seen sooner. On 3/8/22, at 8:48 a.m. R1's significant other (SO) stated R1 has had three surgeries since being admitted to the hospital on 2/17/22, to treat the tunneling PU and he is currently receiving intravenous antibiotics due to the massive infection. SO stated they were in the emergency department (ED) for approximately forty minutes when they were informed R1 would be going to emergency surgery to remove dead tissue from his coccyx. SO stated R1 was in so much pain at the facility and questioned why he was not sent to the ED sooner. SO stated R1 is not expected to live. On 3/08/22, at 12:09 p.m. RN-A stated, when the provider needs to be contacted the procedure is to create an SBAR in PointClickCare (PCC) electronic medical record, print the document, and then fax it to clinic (C)-A. RN-A stated she keeps a paper copy of the SBAR and fax so she can track the request and make sure it is followed up by the provider. RN-A stated residents are usually seen in one to two days after faxing. If it is emergent or an emergency, then the facility will fax and call the provider. RN-A stated R1's PU change in condition and odor was not emergent or an emergency so waiting two days was acceptable. RN-A stated there were no new wound care interventions created after discovering the odor coming from R1's wound. RN-A stated the facility did not change R1 to an air mattress because that needs a provider order and they continued to use the standard facility mattress, even though NP-A had ordered an air altering mattress on 2/7/22. RN-A stated she faxed the change in condition to C-A regarding R1 on 2/15/22. RN-A documented in PCC that the wound had been changing and now it smelled like it was infected. RN-A stated she could smell the bad odor as soon as she entered R1's room and indicated she thought it was dead tissue. RN-A confirmed she faxed the SBAR on 2/15/22, but MD-A did not assess R1 until 2/17/22. RN-A stated there was no investigation of the reason why it took two days for a provider to see R1, even though R1 and R1's room smelled like dead tissue. RN-A stated she followed the facility process for notifying the provider. RN-A stated she has not had any formal training in wound assessments, but she observed the corporate clinical nurse (CCN)-A for a day to complete wound trackers (wound/skin assessments). The observation included how to measure wounds. After the observations, RN-A started completing weekly skin/wound assessment checks independently. On 3/08/22, at 12:18 p.m. director of nursing (DON) stated there was not an investigation or follow up of why R1 was not seen for two days after the SBAR was faxed to C-A. DON indicated with possible necrotic tissue, an SBAR fax should have been submitted with an immediate telephone call to the provider. DON stated MD-A wanted to complete a virtual exam, but she informed MD-A that due to the necrosis, he needed to exam R1 face-to-face. Upon examination, MD-A discussed the seriousness of the wound and that R1 needed to be transported to the ED. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/08/22, at 5:41 p.m. MD-A indicated he was not at a computer and would not be able to share any medical information without looking at R1's chart. MD-A would not state what his expectations would be if he was informed that a resident had possible necrotic tissue, other than someone should assess it. Review of the facility policy, Pressure and Non-Pressure Injuries, original effective date 8/2/21, identified a Stage 4 Pressure Injury as tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone in the ulcer and tunneling often occurs. Tunneling is described as a passageway of tissue destruction under the skin surface. The policy directs the provider be consulted to remove slough or eschar so a Stage 4 PU will be revealed. The immediate jeopardy that began on 2/15/22, was removed on 3/9/22, when the facility assessed all in-house residents skin to ensure there were no unidentified concerns, verified the care plan was up to date, and all findings were reviewed by the interdisciplinary team (IDT); all on-duty staff and all oncoming staff were reeducated on the skin policy; RN-A was assigned further training in Relias Learning Management System on wound and skin assessment and will have education completed by 3/9/22; LPN's were educated by DON starting 3/8/22, regarding RN completing weekly skin assessments, and consistent nurse completing measurements and wound and skin documentation process; LPN staff were reeducated by DON starting 3/8/22, on skin policy including, identifying risks for skin break down, ensuring air mattress as needed and incorporated appropriate interventions and ensuring skin preventions measures in place and care planned; the DON, executive director (ED) and unit managers were educated by DCC that residents with skin impairment are to be assessed for skin impairment risk and interventions to be implemented and care planned based on assessment; skin audits were implemented by DON on wound process, including care plan reviewed and up to date and new interventions put in to place as needed based, IDT review, and includes timely notification of physician and responsible party starting 3/10/22; and the quality assurance/process improvements (QA/PI) committee (composed of ED, DON, unit managers and MD-A) met ad-hoc to review the incident, discuss above action items and audits related to skin integrity and wound care on 3/9/22. A formal QA/PI meeting is to be held and all items and information will be reviewed and follow up on as needed., but the noncompliance remained at the lower scope and severity level of D- no actual harm with potential for more than minimal harm that is not immediate jeopardy.