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	06/16/2022

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 0684 Level of Harm - Minimal harm or potential for 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** 43205 Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, follow physician ordered treatments and care plan for 1 of 4 residents (R2) who developed and had ongoing painful moisture associated skin damage (MASD) Findings include: R2's admission record identified an admitted [DATE], with diagnoses that included: type 2 diabetes mellitus (DM), congestive heart failure (CHF), atrial fibrillation, chronic kidney disease, peripheral venous disease (PVD), and morbid obesity. R2's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R3 had moderate cognitive impairment, did not have behaviors or rejection of care, required limited one person assist with locomotion, extensive assistance with most activities of daily living (ADL's) other than eating. R2 noted to be frequently incontinent of bladder and occasionally incontinent of bowel. The MDS identified R2 was at risk for pressure ulcer development and did not identify moisture associated skin damage (MASD). Skin care interventions included pressure reducing device for chair and bed, application of nonsurgical dressings other than to feet, and applications of ointments/medications other than to feet. R2's skin care plan dated 6/7/22, indicated R2 was at risk for skin integrity conditions and pressure sores related to impaired mobility and incontinence. Interventions included: -Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. -Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. -Frequent repositioning in bed and chair. -Head-to-toe assessment by licensed nurse performed weekly at minimum. -No wipes, only wash cloths with water, and hypoallergenic soap. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's bowel/bladder care plan dated 1/21/22, R2 had alteration in bowel and bladder incontinence related to impaired mobility, mood/behavioral issues, and medication. Interventions included keeping R2 clean and dry, use barrier cream after good peri-care, apply incontinent products as needed. A revised intervention dated 6/9/22, indicated scheduled toileting program every two to three hours and as needed while awake. R2's physician note dated 5/12/22, indicated R2 was frustrated due to the quality of care she is receiving at the facility, skin is being rubbed with scented wipes as she has noted significant irritation with the product, the care she receives overnight, and not being properly dressed with pants as staff are unable to assist. R2 had pain located in her inner thighs due to urine burns related to poor skin care and the products used. Bilateral inner proximal thighs incontinence associated dermatitis with open skin areas. R2 noted with significant erythema, non-blanchable with several small about 1 centimeter (cm) size open skin areas on both proximal inner thighs close to the groin area. No erythema noted underneath her breasts or abdominal pannus/folds. Physician orders included DO NOT USE WIPES - only use a wash cloth, water, and hypoallergenic soap to clean her three times per day and as needed if she is soiled, clean the region with soap and water allowing to dry completely. PAT DRY, DO NOT RUB. Apply barrier cream (zinc oxide). Notify if area affected worsens. R2's physician note dated 5/17/22, indicated R2 stated caregivers have been grumbling and wanting to use regular soap on her skin. Licensed practical nurse (LPN)-A placed several notices in R2's room and bathroom stating not to use regular soap and wipes on R2's skin any longer. Current skin management seems to be helping as no rash nor open areas were noted today. Orders placed to use hypoallergenic briefs and registered nurse (RN)-A notified and will order incontinence products. Physician skin care orders included: -Cleanse groin and intergluteal areas with warm washcloth, pat dry, and apply Clotrimazole cream two times a day until resolved. Once resolved then continue as needed (start date 2/22/22). -Do not use wipes, only use a wash cloth, water, hypoallergenic soap every shift, apply zinc oxide cream 13% topically three times a day for rash and as needed to bilateral proximal inner thighs (start date 5/12/22). R2's record lacked evidence that the order for hypoallergenic briefs from the 5/17/22, visit was transcribed into the medical chart. R2's Treatment Administration Record (TAR) identified R2's prescribed treatments and treatments were not completed per physician orders: -Cleanse groin and intergluteal area with warm washcloth, pat dry and apply Clotrimazole cream two times a day until resolved. Not completed on 5/4/22, 5/6/22, 5/20/22, and 6/9/22. -Peri area and buttocks open to air while in bed. Not completed on 5/4/22, 5/6/22, 5/20/22, and 6/9/22. R2's record was reviewed from 5/1/22 to 6/16/22, although the record identified R2's Weekly skin Reviews were completed, there was a lack of a completed comprehensive assessment. R2's skin reviews are as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 5/16/22, redness in groin and down inner thighs which is currently being treated. -On 5/23/22, no current skin conditions as R2 refused shower and skin check. -On 5/30/22, no current skin conditions. -On 6/4/22, redness in groin from MASD and open area on back/front of right leg. -On 6/7/22, documented blisters, redness, and open area to right lower leg. During an observation and interview on 6/15/22, at 11:52 a.m. LPN-A and NA-F were observed changing R2's saturated incontinent brief. Buttocks, bilateral groins, and abdominal folds observed moist, yeasty, very inflamed, fire engine red, and raw. R2 screamed out in pain as facility staff wiped her buttocks. R2 informed LPN-A and NA-F that some NAs were still using wet-wipes on her skin despite current physician orders and the NAs on nightshift would not even cleanse skin prior to putting on a dry brief. NAs put a new brief back on R2. LPN-A stated R2 was incontinent of bowel and bladder. LPN-A stated they use hypoallergenic incontinence briefs on R2, however, the facility had not ordered yet so not available. An opened package of Cardinal Health Personal Cleaning Cloths - Scented were found in R2's room on top of the dresser. LPN-A took opened package of wet-wipes and placed it on second floor East wing treatment cart. LPN-A stated since R2 had a lot of urinary incontinence staff could not leave her peri area and bottom open to air. During an observation and interview on 6/16/22, at 7:52 a.m. R2 observed sitting on edge of bed with bedside table in front of her. R2 stated she remains in a wet brief until 20 to 30 minutes prior to the end of night shift every night without getting changed. R2 stated she is frequently incontinent and does not always know when the brief is wet. R2 stated her incontinence brief was last changed at 5:30 a.m. During an observation and interview on 6/16/22, at 8:54 a.m. R2 observed sitting on edge of bedside eating breakfast. R2 had not been toileted or changed since 5:30 a.m. During an observation on 6/16/22, at 9:15 a.m. R2's call light observed on. At 9:21 a.m., NA-G answered R2's call light. R2 wanted to use the bedpan to have a bowel movement, NA-G pulled down R2's brief that was saturated with urine and assisted R2 on the bedpan. At 9:37 a.m., NA-G assisted R2 off of bed pan and cleansed R2's skin using wet washcloths and applied DermaCerin barrier cream (moisturizing cream petroleum based, R2 did not have a physician order for this type of cream). NA-G stated she alternates barrier creams every other time with PeriGuard ointment (contains zinc 3.8%). NA-G stated R2 is on a toileting schedule every two to three hours and needs assistance to reposition. NA-G confirmed R2 had not been toileted or her incontinence brief since 5:30 a.m. as she had not assisted R2 yet this morning. NA-G stated she saw wet-wipes in R2's room two weeks ago despite having a physician order not to use them. NA-G stated facility was not using hypoallergenic incontinence briefs yet either. NA-G stated R2 allows staff to properly wash her skin and stated she has never seen a residents buttocks look that reddened and inflamed before. During an interview on 6/14/22, at 2:19 p.m. NA-C stated R2 was a dependent resident with no skin conditions; however, stated R2 required the use of dry tissues, wet washcloths, barrier cream, and could not use wet wipes on skin for cleansing. NA-C did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/14/22, at 3:09 p.m. NA-E stated R2's buttocks were extremely red and sometimes had open areas involved. NA-E stated aides apply different barrier creams to buttocks and nurses will apply dressings to open areas. NA-E stated R2 was on a turning, repositioning, and toileting schedule was every two to three hours and as needed. NA-E stated R2 required the use of wet wash cloths and no wet-wipes were to be used on R2's skin due to allergies. NA-E did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/15/22, at 8:46 a.m. RN-B stated R2 had a very painful, reddened, and inflamed buttocks. RN-B stated R2 required physician orders to cleanse skin with wet washcloth, soap, and water and could not use wet-wipes as it worsened R2's MASD. During an interview on 6/15/22, at 3:28 p.m. NA-A stated R2 was on a toileting and repositioning schedule up to five times per shift. NA-A stated NAs should be assisting R2 to the bedpan a couple times per day. NA-A stated R2 occasionally refuses; however, does well with redirection and reapproach. NA-A stated NA's document refusals and informed nurse each time. NA-A stated R2 could not use wet-wipes due to a skin allergy and was cleansed with soap and water. NA-A stated R2 had MASD and there were signs posted in R2's room and bathroom to alert staff to not use wet-wipes. NA-A did not articulate and/or mention the intervention of R2's peri area and buttocks were to be open to air while in bed. During an interview on 6/15/22, at 12:09 p.m. R2 stated her buttocks burned like hell. R2 stated the night shift NAs do not clean her up well after an incontinence episode; which also occasionally happens on day shift as well. R2 stated staff take off wet brief, do not dry her skin or wash her skin, and re-apply a dry clean brief. R2 stated nurses remove wet-wipes from her room, but then they reappear after they have been removed. R2 stated RN-A completed wound care measurements today; however, was not getting completed every week. During an interview on 6/16/22, at 8:09 a.m. NA-B stated R2's entire buttocks and groin folds were very reddened and moist. NA-B stated facility transitioned from using wet-wipes to using a damp wash cloth or toilet paper and applying barrier cream as needed. NA-B stated R2 will put on call light when she needs to be toileted. NA-B stated she was uncertain if R2 was on a turning, repositioning, or toileting schedule. NA-B stated R2 does not always know when she is incontinent and wet. During an interview on 6/16/22, at 8:29 a.m. LPN-E stated NAs should be following toileting and repositioning schedules every two hours as ordered so all residents skin remained dry and intact. LPN-E stated NAs and nursing staff must follow physician prescribed orders if wet-wipes are not allowed for a resident. LPN-E stated if she found a NA not following orders, she would attempt to re-educate the aide, speak to the unit manager, and possibly the director of nursing (DON) if needed. LPN-E stated concern for further skin breakdown and skin sores that could worsen developing into pressure ulcers (PUs) which could lead to infections and sepsis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/16/22, at 11:16 a.m. LPN-A stated R2's bowel and bladder functioning has declined since she started at facility in February. LPN-A stated R2 is frequently incontinent most of the time. LPN-A stated R2 was on a toileting schedule every two hours; however, was not certain if NAs complete this task as she stated R2 will let staff know when she's incontinent. LPN-A stated NAs do not need to check R2's incontinence brief for dryness. LPN-A stated she had not seen wet-wipes in R2's room in the past two weeks so the package that was found in R2's room on 6/15/22 was recently used on resident. LPN-A stated concern for possible further skin breakdown as R2 is allergic to the wet-wipes that are perfumed. During an interview on 6/16/22, at 11:35 a.m. RN-A stated she thought R2 was not necessarily on a toileting or repositioning schedule. RN-A stated R2 had morning and bedtime cares only or if R2 had an incontinent episode. RN-A stated she asked the staff member who is responsible for ordering supplies to order hypoallergenic briefs one month ago; but has not followed-up to see if R2 received the supplies. RN-A stated facility does not have hypoallergenic soap as they use the total bath and body wash which is orange colored. RN-A stated she would have to follow-up on the soap. RN-A stated R2 did not have MASD or skin sensitivity redness a few months ago and R2's skin has worsened. RN-A stated she would need to re-educate nursing staff on following physician orders to not use wet-wipes on R2's skin despite efforts LPN-A had utilized with posting signs on R2's room and bathroom. RN-A stated her concern of staff using wipes and applying dry brief over non-cleansed soiled skin could lead to further skin breakdown and possible infection. RN-A stated that weekly skin assessments are to be completed on bath days. Facility has bath sheets that the aide fills out and gives to the floor nurse to be signed and reviewed; then turned in to RN-A for final review. RN-A stated these were not completed by floor nurses and was not certain if skin conditions had been addressed. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A admitted she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans During an interview on 6/16/22, at 1:09 p.m. DON stated expectation for pressure and non-pressure wounds to be documented and measured weekly on all residents, turned and repositioned according to orders, and checked and changed as ordered, reminding and reapproaching residents on importance of repositioning, and following doctor prescribed wound care as ordered. DON indicated risk factors that may lead to worsening or new development of PUs which included, not repositioning timely, following physician orders, range of motion, and debility. DON stated an awareness of wound supply shortages. DON stated facility does IDT or weekly at risk (WAR) meetings every Wednesday to discuss new admissions, falls, skin concerns, new behaviors, service intensive families, new antibiotics in the past week, nutritional needs and weights, and any other concerns or issues identified with all residents. DON stated care plans and interventions were updated after IDT meetings by herself, MDS nurse, or RN-A. DON indicated if care plans were not updated; then residents were not receiving the best possible care and staff would not complete what needs to be done. DON stated her expectation for nursing staff to assist R2 with toileting, check and change her incontinence brief, and reposition her so the MASD does not cause further skin breakdown. DON stated facility has been unable to locate any hypoallergenic incontinence briefs for R2. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Pressure and Non-pressure Injuries dated 8/2/21, indicated this center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. -A head-to-toe body evaluation will be completed on every resident upon admission/readmission and will be documented on the Admission/Readmission Evaluation UDA. -Initiate the Pressure Injury Weekly Tracker UDA - one per wound. -Ensure primary care physician (PCP) is aware of wounds/location of wounds and current treatment orders. -Ensure resident/responsible party is aware of wounds and current treatment plan. -Ensure appropriate treatment orders for each wound area, as needed. -Initiate the baseline plan of care related to current skin status and skin risk level. -Complete a head-to-toe skin check and document findings on the Skin Review - Weekly NSHC UDA. -Assess current wounds at least every seven days, or more frequently as needed (e.g., decline in wound, presence of infection, wound healed). If a wound fails to show some evidence of progress toward healing within 2-4 weeks, the area and the resident's overall clinical condition should be reassessed. Re-evaluation of the treatment plan includes determining whether to continue or modify the current interventions. Results may vary depending on the resident's overall condition and interventions/treatments used. The complexity of the resident's condition may limit responsiveness to treatment or tolerance for certain treatment modalities. The clinicians, if deciding to retain the current regimen, should document the rationale for continuing the present treatment to explain why some, or all, of the plan's interventions remain relevant despite little or no apparent healing.

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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** 43205 Based on observation, interview, and document review, the facility failed to prevent pressure ulcers development or deterioration and promote healing by failing to follow physician ordered treatments, follow the care plan, and ensure comprehensive assessments and monitoring for 2 of 4 residents (R1 and R3) reviewed for pressure ulcers. The facility's failures resulted in actual harm for 2 of 4 residents (R1, R3) when new ulcers developed and/or worsened. The deficient practice has the potential to effect all residents in the facility that are at risk for pressure ulcers. Findings include: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage 3 Pressure Ulcer: Full-thickness of the skin may extend into the subcutaneous tissue layer; granulation tissue and epibole (rolled wound edges) are often present. At this stage, there may be undermining and/or tunneling that makes the wound much larger than it may seem on the surface. R1's hospital discharge summary dated 3/1/22, indicated R1 had new dermatitis in gluteal cleft associated with incontinence that developed on 2/18/22. R1's admission record identified an admitted [DATE], with diagnoses that included: Parkinson's disease, dementia without behavioral disturbance, peripheral vascular disease (PVD), and chronic obstructive pulmonary disease (COPD). R1's Minimum Data Set (MDS) assessment dated [DATE], indicated R1 had moderately impaired cognition, no behaviors or rejection of care, required supervision with eating, and extensive two-person assistance with all other activities of daily living (ADL's) and used a wheelchair for mobility. MDS identified R1 was frequently incontinent of bowel and bladder. The MDS also identified R1 was at risk for pressure ulcers and did not have pressure ulcers or other impaired skin integrity (the MDS did not identify R1's impaired skin integrity according to the record); associated interventions included pressure reducing device for chair and bed, application of nonsurgical dressings other than to feet, and applications of ointments/medications other than to feet. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's admission physician note dated 3/4/22, indicated R1 was negative for any skin integrity conditions including wounds. On 3/10/22, physician note indicated R1 was negative for wounds R1's care plan dated 3/10/22, indicated urinary incontinence and bowel related to impaired mobility and will be free from skin breakdown and be maintained in as clean and dry, dignified state as possible. Care plan indicated R1 had actual skin integrity break and/or pressure sore(s) - see wound assessment pressure sore, skin tear - bilateral legs, elbows, underlying PVD, upper extremity fractures, and COPD. On 3/23/22, revised interventions included: -Assess and measure all skin integrity areas per policy. -Follow pressure ulcer prevention guidelines to prevent additional skin problems, promote health, and prevent complications. -Initiate skin monitoring forms per facility policy. -Initiate treatment per physician order. -Monitor and report any new open areas, draining, increased drainage or pain to nurse immediately. -Provide treatment to wound(s) per current treatment order. Assess wound(s) for signs and symptoms (s/s) of infection with each dressing change/treatment. Report findings of redness, warmth, swelling, increased drainage or increased pain to physician immediately. -Report wound progress or decline to medical doctor (MD) with any changes or lack of response to treatment per facility guidelines. R1's record was reviewed between 3/1/22 to 5/31/22. The record identified R1 was admitted to the facility with moisture associated skin damage and within two weeks of admission developed a stage 2 PU that continued to deteriorate to a stage 3. R1's record identified the physician had been following R1's wounds after notification and provided new treatment orders as the wound changed. However, in review of R1's treatment administration record and interviews, the treatments were not always completed per physician orders. The record also identified the facility was not completing comprehensive weekly skin assessments that would identify or determine potential causal factors and modifiable risk factors for appropriate care plan interventions that would reduce the risk of worsening and/or new pressure ulcer development. R1's progress note dated 3/6/22, indicated R1 had developed pressure areas on his coccyx and elbow. R1's record lacked a comprehensive assessment and physician notification. R1's progress note dated 3/9/22, indicated R1 now had a red open area on his coccyx and the physician was notified. A Non-pressure Weekly Tracker form was completed on 3/10/22, with wound measurements and description which included open area on sacrum which was pink and blanchable. The center has an open area that measures 1.4 cm x 1.1 cm x 0.1 cm. Skin is pink, no drainage, no odor, and no tunneling or undermining. R1's record lacked a comprehensive assessment for causal factors. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's physician visit dated 3/15/22, identified open area at sacrum measuring 1.4 centimeters (cm) x 1.1 cm x 0.1 cm. Skin around area is pink. Wound continued to heal with pink skin area, no worsening open area or drainage. Nursing to continue to keep it clean and covered with a bordered foam dressing. Nursing was instructed to offload/turn resident at least three times daily to prevent further skin break. Nursing to continue monitoring skin with weekly skin check and update physician if worsening skin area. R1's wound tracker dated 3/17/22, included open area on sacrum measuring 1.4 cm x 0.7 cm x 0.1 cm and indicated wound was improving. R1's physician visit dated 3/23/22, indicated given the onset of coccygeal wound, he is getting closer to being appropriate for hospice. R1's Wound Tracker dated 3/24/22, indicated open area on sacrum measuring 1.7 cm x 1.0 cm x 0.5 cm and indicated wound was worsening and notified nurse practitioner on 3/22/22. R1's physician visit dated 3/30/22, indicated registered nurse (RN)-A reported coccyx is healing well without redness, drainage, or signs of infection. R1 enrolled with hospice on 3/30/22 per family consent R1's physician visit dated 4/1/22, indicated moisture associated open skin damage measuring 1.5 cm x 0.8 cm x 0.3 cm. R1's record included subsequent weekly Wound Trackers completed on 3/31/22, 4/7/22, 4/14/22, 4/21/22, 4/27/22. The wound trackers indicated the wound measurements remained relatively consistent in size and depth, however, continued to lack a comprehensive assessment to identify and remove potential causal factors. R1's physician visit dated 5/2/22, indicated R1's sacrum PU stage 3 and measured 1.5cm x 0.5 cm x 0.3 cm. R1's record identified weekly Wound Trackers were not completed after 4/27/22 through 5/19/22. R1's weekly Wound Tracker dated 5/19/22 included open area on sacrum measuring 1.5 cm x 0.6 cm x 0.4 cm. On 5/26/22, RN-A documented open area on sacrum measuring 2.2 cm x 1.0 cm x 0.4 cm and peri-wound tissue pink or normal for ethnic group; but indicated wound was worsening with larger open area measurements. (continued on next page)

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	245184	A. Building B. Wing	06/16/2022

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

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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 0686 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 6/15/22, at 12:36 p.m. hospice registered nurse stated R1 was admitted to hospice on 3/31/22, with diagnoses of Parkinson's dementia and an unstageable PU on coccyx. Hospice RN stated she did not visualize the coccyx wound upon admission as facility LPN-B stated the wound was currently stable. Hospice nurse coordinated with LPN-B to be able to assess and change coccyx dressing on the second visit on 4/7/22; however, when hospice nurse called facility on 4/7/22, at 8:40 a.m. LPN-B stated she had already completed wound care for R1. LPN-B stated coccyx wound was stable, appeared smaller, and facility was continuing on with current treatment orders of acidic acid soaks and mepilex dressing. On 4/28/22, hospice RN had a conversation with RN-A who stated the coccyx PU length and width were staying the same and the dimensions were getting shallower with acidic acid gauze. Hospice RN stated she was uncertain if facility was staging PU at this time. On 4/28/22, hospice nurse stated R1's coccyx wound was upgraded to a stage 2 PU with scant drainage and measured 1.6 cm x 0.5 cm x 0.4 cm with undermining and slough present and she completed dressing change and measurements with RN-A. On 4/29/22, hospice physician wound care orders were faxed to the facility for wound care coccyx pressure area: cleanse with wound cleanser (i.e. Skintegrity) and gauze, allow to dry. Apply skin protectant (i.e. Sure-prep wipe) to intact peri-wound skin, let dry. Apply bordered gauze dressing. Perform wound care every three days and as needed for soiling and loosening. Routine wound care was to be performed by facility staff per these orders. Hospice nurse stated she faxed over the new wound care orders. Hospice nurse stated she then started noticing there was a pattern with R1 not being provided wound care per physician orders. There was a total of three to four visits made by the hospice RN when there was no dressing in place on R1's coccyx wound. Hospice nurse stated she brought this to the attention of RN-A; RN-A stated the facility had supply issues and there were no bordered dressings to cover the wound. Hospice RN stated it became pattern for facility to not have supplies for R1 so she brought supplies with her and gave facility supplies to use. On 5/24/22, hospice RN stated R1 was found with bowel incontinence in his brief and no dressing found on coccyx wound. Hospice RN stated wound was upgraded to stage 3 PU with undermining, surrounding skin tissue erythema, scant drainage, and measured 1.5 cm x 0.6 cm x 0.5 cm. Hospice RN was unable to locate RN-A at this time to notify her of worsening PU; but notified the floor nurse. On 5/26/22 at 12:10 p.m., hospice nurse called RN-A discussing her concerns with R1 repeatedly found without proper physician prescribed dressings in place for his coccyx PU. On 5/31/22, hospice nurse completed last visit with R1 prior to him discharging to hospice house. R1 was found in bed without coccyx dressing in place with a worsening Stage 3 Coccyx PU which then measured 2.0 cm x 1.2 cm x 0.5 cm with undermining and erythema on surrounding skin. R1 was showing some signs of terminal decline, more swallowing decline, and hospice believed he was already transitioning at that time. R1's treatment administration record (TAR) identified physician orders which included apply in house barrier cream and cover open area with large mepilex 4x4 to coccyx once every day-shift and to update physician if worsening skin area starting on 3/12/22. On 3/24/22, the order was changed to apply acetic acid solution-soaked gauze twice daily and as needed and cover with mepilex dressing. Treatment was not completed on 3/26/22, 4/1/22, 4/9/22, 4/11/22, 4/15/22, 4/18/22, 4/20/22, 4/24/22, 4/25/22, 4/26/22, 4/27/22, and 4/29/22. On 5/3/22, order indicated to cleanse wound with wound cleanser and gauze and allow to dry. Apply skin protectant (i.e. Sure-prep wipe) to intact peri-wound skin, let dry. Apply bordered gauze dressing. Perform wound care every three days and as needed for soiling or loosening. Notify hospice if worsening, has increased drainage, size redness, warmth, pain. Treatment was not completed on 5/3/22 and 5/12/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	When interviewed on 6/15/22, at 3:28 p.m. nursing assistant (NA)-A stated R1 was incontinent of bowel frequently and required frequent checks and changes. NA-A stated aides would get floor nurse to change R1's coccyx dressing if soiled or if it fell off. NA-A stated R1 was repositioned every 2 hours and was unable to sit up in his wheelchair towards the end due to increased pain in coccyx area. When interviewed on 6/16/22, at 8:09 a.m. NA-B stated R1 had a stageable PU on his coccyx that was deep and worsened over time since his admission to facility. NA-B stated she found R1 without coccyx dressing in place usually in the mornings after night shift would say R1 was incontinent of bowel. NA-B stated aides were to notify nurses if dressing was soiled so a new one could be applied. NA-B stated R1 would grimace in pain if bowel movement in the wound and staff had to clean it out and when the nurses had to measure the depth of the wound. When interviewed on 6/16/22, at 11:35 a.m. RN-A stated a comprehensive head-to-toe assessment is completed on every resident upon admission, quarterly, and at change of condition which included: skin and bowel assessments. RN-A stated that weekly skin assessments are to be completed on bath days. Facility has bath sheets that the aide fills out and gives to the floor nurse to be signed and reviewed; then turned in to RN-A for final review. RN-A admitted these were not completed by floor nurses, RN-A had found them not signed and dated by floor nurses, so she was uncertain if the skin conditions had been addressed. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A stated R1 developed a stage 1 PU on his coccyx after his admission to facility. RN-A stated she completed R1's admission comprehensive assessment; however, failed to complete a thorough skin assessment which included looking at R1's buttocks. RN-A stated she found R1's open area on coccyx and moisture associated skin damage (MASD) two weeks after admission to facility. RN-A stated she was aware R1 was found numerous times without proper wound care dressings to his PU and floor nurses would report to her that oh, I was just going to put that on now. RN-A stated R1 was frequently incontinent of stool and the coccyx dressing needed to be replaced; however, was not completed often because of some staff completely disregarded R1's need. RN-A stated the aides would get R1 cleaned up well but citric acid was not used by nursing staff to cleanse the inside of R1's wound during incontinence episodes as it should have been. RN-A stated R1 was on a turning and repositioning schedule every two hours; but thought this was not getting completed by aides timely. RN-A admitted she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated facility completes weekly interdisciplinary team (IDT) meetings on Wednesdays which included: Administrator, DON, RN unit manager, MDS nurse, and dietician. RN-A stated she was unable to go to these meetings in May as she was working as a floor nurse primarily. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans. During a returned call telephone interview on 6/21/22, at 1:17 p.m. NP stated R1 was admitted to facility without a PU. NP stated physician was notified approximately two weeks after admission that R1 developed an open area on his coccyx. NP expressed concern of not being able to find facility staff to assist with wound measurements and dressing changes when at facility which could have affected R1's care he received. NP stated she initiated a wound care protocol for DON to give her a list of all residents with current wounds every Friday at 9:00 a.m. for physician rounds so they were able to properly assess and measure all PUs and non-pressure ulcer wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's admission record identified diagnoses that included: dementia with behavioral disturbance, type 2 diabetes mellitus (DM), anxiety, and eczema. R3's quarterly MDS assessment dated [DATE], indicated R3 was cognitively intact, displayed no behaviors or rejection of cares, required setup help for most ADL's, however required limited one-person assist for dressing and personal hygiene. The MDS identified R3 had occasional incontinence of bladder. R3's MDS indicated R3 was at risk for pressure ulcer development, did not have pressure ulcers, however, did have MASD, skin care interventions included pressure reducing device for chair and bed and application of ointments/medications other than to feet. R3's care plan dated 8/13/18, indicated R3 was at risk for bowel and bladder incontinence as evidenced by the resident needing some assistance with toileting as needed due to dementia, anxiety, weakness, and use of diuretic. Provide incontinence care/perineal care after each incontinent episode and use barrier cream each time. R3 was at risk for skin integrity related to dementia, weakness, dermatitis/eczema, sleeps in recliner per resident choice, MASD to chest area/under breasts/groin/right buttocks with interventions that included: -Conduct pressure injury skin assessments (i.e. Braden scale) as indicated. -Assess skin for redness or pressure related changes with each care encounter. Report any changes immediately. Head-to-toe assessment by licensed nurse performed weekly at minimum (revision date 2/11/22). -Administer medications per MD order. Resident refuses treatment at times. Encourage her to allow treatment (revision date 6/8/22). -Keep resident clean and dry. Use barrier cream after good peri-care. Apply proper incontinent products. Encourage resident to allow staff to assist in cares. Resident has history of refusing due to wanting to remain as independent as possible (inconsistent with MDS dated [DATE]). Education given on risks of completing own cares as resident does struggle with thoroughness of task (revised on 6/16/22). R3's physician orders included: -Right buttock and left perineal area: apply mepilex border to area and change every three days and as needed if soiled. Interdry to groin area. Change twice daily every morning and at bedtime (start date 4/19/22). -Nursing to check perineal area for proper wiping/cleaning/document refusal at bedtime (start date 4/22/22). -Nursing to check perineal area every shift and update provider if worsening skin area (start date 6/13/22). R3's record was reviewed between 3/31/22 to 6/16/22. Weekly Skin Reviews were reviewed in conjunction with non-pressure weekly trackers and physician notes. The record identified worsening skin integrity and the development of pressure ulcers after R3 had MASD. The record lacked ongoing weekly comprehensive skin assessments and treatments not completed according to physician orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Weekly non-pressure tracker dated 3/31/22, included facility acquired open area on right buttocks MASD increased in size measuring 1.0 cm x 0.5 cm x 0.1 cm was bright red and/or blanches to touch. Physician visit note dated 3/31/22, indicated facility requesting evaluation of right buttock open wound with redness that they have been dressing with border foam to cover. -Weekly non-pressure tracker dated 4/7/22, included an open area on right buttock measuring 0.5 cm x 0.3 cm x 0.1 cm and indicated wound was improving. A facility acquired open area on left perineal area MASD measuring 1.0 cm x 0.3 cm x 0.1 was pink or normal for ethnic group. Physician visit included dated 4/7/22, included nursing reported R3's periarea is very raw, red, and inflamed in periarea. She does refuse for personal cares to be done frequently. Today, NP assessed the MASD to right buttock area measuring 0.3 cm x 1cm and left perineal MASD measuring 0.57 cm x 0.3 cm x 0.1 cm. NP discussed new dressing and Nursing was instructed to continue monitoring skin with weekly skin check and update provider of worsening skin area. -Weekly non-pressure tracker dated 4/12/22, indicated an open area on right buttock measuring 0.4 cm x 0.3 cm x 0.1 cm was bright red and/or blanches to touch. Left perineal are MASD measuring 0.9 cm x 0.3 cm x 0. 1 cm. -Weekly skin review dated 4/21/22 indicated R3 had a small open area on her perineum; no other information about the area was documented. -Weekly skin review dated 4/28/22 indicated R3 had a small open area on coccyx; no other information about the small open area was documented. R3's record did not include completed skin reviews and/or non-pressure weekly trackers between 4/29/22 and 5/18/22. R3's physician visit dated 5/6/22, indicated right buttock area MASD improving and groin rash has resolved per nursing. No further physician visits were provided that addressed R3's wounds. -Weekly skin review dated 5/19/22, indicated R3 had an area on left labia which is currently being treated. R3's record did not include completed skin reviews and/or non-pressure weekly trackers between 5/20/22 and 6/5/22. -R3's weekly skin review dated 6/6/22, included open excoriated areas on mons pubis and labia from scratching. Raw, reddened skin on right buttock measuring 4.5 cm x 6.0 cm with smaller open are in the middle measuring 1.5 cm x 1.0 cm. The corresponding non-pressure weekly tracker dated 6/6/22 was inconsistent with the weekly tracker; the non-pressure tracker only identified open area on right buttock measuring 1.5 cm x 1.0 cm x 0.1 cm. The next skin tracker that was completed on 6/16/22. The weekly skin review and the non-pressure tracker were inconsistent. The non-pressure weekly tracker dated 6/16/22, included an open area on right buttock measuring 0.9 cm x 0.5 cm x 0.1 cm. Whereas the weekly skin review dated 6/16/22 included, right and left buttock with open areas of concern to coccyx and right/left buttock. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's record lacked comprehensive wound assessments for all the areas identified on the tracking forms. In addition, the record lacked identification of potential causal factors and/or modifiable risk factors contributing the deterioration of R3's that could otherwise be removed to ensure healing, reduce the risk of deterioration, and new ulcer development. Review of R3's TAR identified the physician orders and also indicated several occasions when R3 was not provided skin treatments per physician orders. - Right buttock and left perineal area: Apply Medi-honey to right buttock and left perineal and cover with 2x2 foam dressing. Once daily and as needed. Update provider if worsening to be completed every dayshift. Not completed on the following dates: 4/9/22, 4/10/22, 4/15/22, 4/18/22, 4/19/22, and 5/2/22. -Right buttock and left perineal area: Apply Mepilex border to area and change every three days and as needed if soiled on dayshift. Not completed on the following dates: 4/20/22, 4/23/22, 4/26/22, 4/29/22, 5/2/22, 6/3/22, and 6/9/22. -Interdry to groin area. Change twice daily every morning and at bedtime. Not completed on 4/20/22, 5/19/22, 6/2/22, 6/6/22, 6/7/22, 6/8/22, and 6/9/22. -Nursing to check perineal area for proper wiping/cleaning at bedtime. Document refusal. Not completed on 6/3/22 and 6/9/22. During an interview on 6/14/22, at 2:19 p.m. NA-C stated R3 currently had multiple sores on her buttocks and thigh area that staff are cleaning twice a shift. NA-C stated there were no dressings ordered to be applied to open wounds. During an observation on 6/15/22, at 8:31 a.m. R3 observed sitting in grey recliner in corner of room with breakfast tray. Surveyor could smell stale, foul urine from the doorway of R3's room. During an observation and interview on 6/15/22, at 10:08 a.m. R3 laid in bed, RN-B at bedside to change R3's dressings. R3 did not have prescribed bordered foam dressing to open sores on right and left buttocks, bilateral mons pubis area, nor interdry in groin folds. RN-B indicated R3 had two open sores to right buttocks (one circular and the other a large, long rectangular shaped slit), one open sore to left buttocks, one open sore on left mons pubis perineal area, and one open sore on right mons pubis perineal area. RN-B stated the area was very reddened to almost darkened purplish colored and moist. RN-B stated she measured all wounds which included pressure and non-pressure sores; but was uncertain how often this task gets completed. RN-B applied one 4x4 mepilex to two right buttocks stage 2 PUs and one mepliex applied to left stage 1 PU on left buttocks. RN-B stated facility did not apply dressing to open areas to mons pubis perineal area. RN-B stated R3 is very active during the day and transfers independently so is not on a repositioning schedule. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on 6/16/22, at 10:30 a.m. R3 observed walking with NA-B to go to third floor whirlpool tub for bath. NA-B assisted R3 to remove her clothing; physician ordered dressings were not in place on her buttocks nor interdry in her abdominal folds. Surveyor observed R3 with two open areas on right buttocks, one small open area on left buttocks, and bilateral openings on mons pubis perineal area. At 10:57 a.m. LPN-E completed dressing changes to R3's bottom. LPN-E indicated the small circular opening on left buttocks and right long rectangular shaped opening on right are new wounds since 6/10/22 when she had last worked. During an interview on 6/15/22, at 8:46 a.m. RN-B stated R3 has sores on her buttocks, lower extremities from eczema, redness in bilateral groin folds and abdominal folds that require interdry placed in folds. RN-B stated R3 was incontinent of bladder frequently and wore a brief. During an interview on 6/15/22, at 9:00 a.m. R3 stated she did not have any current open sores on her skin. R3 stated she used to have sores on her buttocks, but facility staff bandaged them up and they healed up right away. R3 stated she was continent of bowel and bladder and was independent with transfers and locomotion. R3 had some notable forgetfulness during interview as R3 was unsure why she wore an incontinence brief. During an interview on 6/15/22, at 4:20 p.m. NA-D stated R3 was alert, oriented, and independent with all cares. NA-D stated R3 wore an incontinence brief as she had some episodes of incontinence. NA-D stated R3 wanted to remain independent. During an interview on 6/15/22, at 4:05 p.m. RN-C stated R3 has had open areas on her buttocks and perineum, but they have since healed up and closed even though according to NAs R3 had open areas on 6/14/22 and the surveyor's observation earlier that day. RN-C stated NAs should be checking on R3 every two hours or as needed. RN-C stated if R3 refuses, aides should be redirecting resident or checking back with her shortly. RN-C stated R3 is incontinent of bladder at all times and R3's dementia is quite off sometimes and speaks about a past doctor who she takes recommendations from. During an interview on 6/16/22, at 8:09 a.m. NA-B stated R3 was alert, but often very forgetful due to her dementia. NA-B stated R3 listens to a MD from years past so they often redirect R3 informing her the MD is okay with cares. NA-B stated R3 has multiple open areas on buttocks and mons pubis perineal area and stated these were open on her shift on 6/12/22. NA-B stated R3 has reddened groin folds, underneath bilateral breasts, and on perineal area. NA-B stated these were very enflamed, swollen, sore, and painful for R3. NA-B stated aides are to be checking on R3's incontinence brief two to three times per shift and checking and changing as appropriate. NA-B stated she believed this was not part of the aide tasks on EHR; however, the information is passed along in verbal shift report. During an interview on 6/16/22, at 8:29 a.m. LPN-E stated R3 had an order to dress open areas on right and left buttocks with mepilex every three days or as needed for soiling. LPN-E stated R3 will refuse; however she would respond easily with redirection or reapproach. LPN-E stated NA's should be alerting nurses if they need assistance for redirection. LPN-E stated there were only certain NAs who were aware of correct cares and completed them well. LPN-E stated R3 was incontinent of bladder all the time and wears an incontinence brief. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/16/22, at 11:35 a.m. RN-A stated R3's buttocks opened up in March. RN-A confirmed R3's skin wound measurements were not completed the weeks of 5/26/22 and 6/2/22. RN-A stated her concern would be failure to track and trend progression or healing of the wounds if there are no weekly skin measurements completed. RN-A stated R3 has dementia and is quite forgetful following a TBI. RN-A stated R3's dressing should be in place per physician orders at all times. RN-A verified R3 there was not a task list or care plan for NAs to know R3 should have a dressing in place at all times. RN-A stated she had fallen behind on completing these timely. RN-A stated weekly skin trackers are to be completed by her every seven days on residents with pressure and non-pressure related wounds. RN-A stated she was not keeping up on weekly wound measurements and completing management duties as she was pulled to work the floor as a nurse. RN-A stated wounds and PUs were reviewed during their IDT meetings which included updating the plans of care and interventions for residents; however, was uncertain if these were getting completed timely as DON primarily updated care plans. During an interview on 6/16/22, at 1:09 p.m. DON stated expectation for pressure and non-pressure wounds to be documented and measured weekly on all residents, turned and repositioned according to orders, and checked and changed as ordered, reminding and reapproaching residents on importance of repositioning, and following doctor prescribed wound care as ordered. DON indicated risk factors that may lead to worsening or new development of PUs which included, not repositioning timely, following physician orders, range of motion, and debility. DON stated an awareness of wound supply shortages. DON stated facility does IDT or weekly at risk (WAR) meetings every Wednesday to discuss new admissions, falls, skin concerns, new behaviors, service intensive families, new antibiotics in the past week, nutritional needs and weights, and any other concerns or issues identified with all residents. DON stated care plans and interventions were updated after IDT meetings by herself, MDS nurse, or RN-A. DON indicated if care plans were not updated; then residents were not receiving the best possible care and staff would not complete what needs to be done. During a returned telephone interview on 6/21/22 at 1:17 p.m. NP expressed concern of not being able to find facility staff to assist with wound measurements and dressing changes when at facility which could have affected R1's care he received. NP stated she initiated a wound care protocol for DON to give her a list of all residents with current wounds every Friday at 9:00 a.m. for physician rounds so they were able to properly assess and measure all PU's and non-pressure ulcer wounds. NP stated R3 has dementia with significant cognitive impairment. NP stated she thought R3's worsening skin conditions including MASD were related to R3 not receiving good perineal care following incontinence episodes. The facility policy titled Pressure and Non-pressure Injuries dated 8/2/21, indicated this center will complete a comprehensive assessment to identify risk factors for the development of pressure injuries and put in place measures intended to achieve the goal of prevention of pressure injuries in our residents. For those residents admitted with, or who subsequently dev