| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245289 | A. Building<br>B. Wing | 08/09/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>Crystal, MN 55422 |

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 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on observation, interview and document review, the facility failed to protect 4 of 4 (R2, R5, R9, R10) residents from resident-to-resident abuse when R1 physically abused them. In addition, the facility failed to implement immediate and ongoing interventions to keep residents safe from further abuse which resulted in an immediate jeopardy (IJ) situation for (R2, R5, R9, R10) and potential for harm, injury, impairment, or death to all 19 residents currently residing on the 2nd floor memory care unit.<br><br>The immediate jeopardy began on 7/11/22, when R1 was observed to bite R5 and facility failed to implement interventions to protect other residents from R1's behaviors, which lead to additional resident to resident physical altercations, and was identified on 8/3/22. The administrator, director of nursing, social service assistant, dietary director, and business office manager were notified of the IJ at 6:38 p.m. on 8/3/22. The immediate jeopardy was removed on 8/5/22, but noncompliance remained at the lower scope and severity level 2 scope and severity level of an E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br><br>Findings include:<br><br>R1's annual Minimal Data Set (MDS) dated [DATE], indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors.<br><br>R1's care plan dated 12/14/19, indicated R1 had a history of being physically aggressive by hitting other residents. R1's care plan lacked evidence of interventions for safeguarding vulnerable residents living with/near vicinity of R1.<br><br>R2's quarterly MDS dated [DATE], indicated R2 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R2 did not exhibit behaviors.<br><br>R9's quarterly MDS dated [DATE], indicated R9 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R9 exhibited delusional behavior.<br><br>R10's quarterly MDS dated [DATE], indicated R10 had a diagnosis of dementia and had cognitive impairments. Further review of MDS, indicated R10 did not exhibit behaviors.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of facility report to the State Agency (SA) dated 7/11/22, indicated R1 was observed to have R5's thumb in her mouth (biting). Review of facility's 5-day investigation lacked evidence of actions implemented to protect other residents from R1's physical behaviors.<br><br>Review of facility report to the SA dated 7/23/22, R1 was observed making threats towards R2 punched R2 on the arm. At the time of the incident, R1 and R2 shared the same room. Review of facility's 5-day investigation lacked evidence of actions implemented to protect R2 from further abuse as well as other residents from R1's physical behaviors.<br><br>On 8/1/22, at 3:00 p.m. R1 and R2 were observed in their shared room with the door closed.<br><br>On 8/3/22, during continuous observation starting at 1:27 p.m. surveyor heard screaming coming from the day room (open common area that include nursing station/hallway threshold /day room). Surveyor observed R1 continuing to yell out in the day room while additional staff removed R9 from the day room while she made comments such as, she grabbed my arm and she hit me hard referring to R1. R1 remained in the day room with other residents. At 1:40 p.m. R1 was observed still upset and yelling in the dayroom while speaking with social services (SS)-A. SS-A was observed to leave R1 in the day room as R1 continued to be upset. R1 was then observed to self-propel in her wheelchair to R10 who was sitting in his wheelchair in the day room and kicked his shin. Trained medication aide (TMA)-B and registered nurse (RN)-A intervened and separated R1 and R10. Staff removed R10 from the day room, however, R1 remained in the day room area with other residents. R1 moved near nursing station area. Surveyor was in the commons area by nursing station with R1, no other facility staff were in the area. R1 was observed to be making threatening gestures towards another resident in the area and sticking her tongue out. At 1:56 p.m. R1 continued to be upset and making threatening gestures to another resident in area and began to self-propel in her wheelchair to resident while staff was at the nursing cart and staff was able to intervene.<br><br>On 8/3/22, 2:35 p.m. R1 was observed in the commons area with other residents and the nursing station was unsupervised.<br><br>On 8/2/22, 10:26 a.m. nursing assist (NA)-A indicated R1 was physical with staff and residents a lot and interventions were to reapproach and while in the commons area with other residents staff are to watch and a staff member was expected to sit in the room while R1 was in the commons area.<br><br>On 8/2/22, at 11:36 a.m. NA-B stated she was assisting R1 and R2 with morning cares when R1 became aggressive and beat R2 on her arm, wrist and leg. R2 then got upset and hit R1 on her arm and legs. Further, NA-B stated she was not sure what intervention was implemented following the incident as it is not my job to decide what to do.<br><br>On 8/2/22, at 12:02 p.m. TMA-A stated R1 had an explosive temper and you can't come close to her, or she will hurt you.<br><br>On 8/2/22, at 4:53 p.m. social services (SS)-A stated R1 had physical behaviors and can't be near most residents. Further SS stated staff were expected to separate R1 from other residents by 3-4 feet when agitated to give her some space. SS confirmed there were no additional intervention implemented following R1's incidents with R2 and R5.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 8/3/22, at approximately 1:30 p.m. TMA-B stated R9 was attempting to sit behind R1 in the recliner when her walker bumped into R1 which caused R1 to hit R9 on her arm.<br><br>On 8/3/22, at approximately 1:35 p.m. health unit coordinator (HUC)-B confirmed she witnessed R1 slap R9 on her arm.<br><br>On 8/3/22, at 2:12 p.m. NA-E indicated she was not aware of R1's history of aggressive behaviors towards other residents.<br><br>On 8/3/22, at 2:34 p.m. R9 was laying in her bed and immediately became tearful and stated, I didn't do anything, I was going to sit in the chair, and she started pounding on me. I am scared of her; she should be in a different area. I guess I will just stay in my room and go out for meals and not go out there by her.<br><br>On 8/3/22, at 3:25 p.m. TMA-B indicated she was not aware of R1 having a history of being physically aggressive with other residents. When asked how staff protect other residents when R1 is upset, TMA-B stated she had never been in a situation where she felt she needed to protect other residents from R1.<br><br>On 8/3/22 at 4:35 p.m. interview with nurse manager and director of nursing (DON) stated SS was in charge of the investigation and implementing interventions following the determination of a root cause. DON stated staff were expected to keep residents safe and separate residents following an altercation, so another incident does not occur. DON confirmed R1's care plan had not been updated with interventions for physical behaviors since 2019 and the care guide sheet as of 8/3/22, had no safety interventions for R1's behaviors.<br><br>Review of facility policy titled Reporting Abuse to Facility Management, not dated, indicated the facility does not condone resident abuse by anyone including other residents.<br><br>Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, directed staff to protect residents during abuse investigations. Further review of abuse policy lacked evidence of clear guidance on how staff will immediately protect residents following a resident to resident altercation and implementing appropriate interventions following an altercation.<br><br>The immediate jeopardy that began on 7/11/22, was removed on 8/5/22 at 1:55 p.m., when the facility updated R1's care plan to include behavioral interventions such as encouraging R1 to engage in appropriate activities, prevent over crowding or close enough to touch others, R1 was moved to a private room, and assigned nursing assistant to transport R1 to and from dining area or lounge and R1 to remain within eye sight of staff. In addition, staff's care guides were updated to reflect R1's interventions, staff were educated on updated interventions as well as abuse and reporting, but noncompliance remained at a lower scope and severity level of an E, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on interview and document review, the facility failed to implement their abuse policy related to reporting incidents of resident-to-resident abuse for 2 of 4 residents (R9, R10) who were reviewed for abuse. In addition, the facility failed to develop clear guidelines for protection of the resident during completion of a thorough investigation.<br><br>Findings include:<br><br>R1's annual minimal data set (MDS) dated [DATE], indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors.<br><br>R9's quarterly MDS dated [DATE], indicated R9 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R9 exhibited delusional behavior.<br><br>R10's quarterly MDS dated [DATE], indicated R10 had a diagnosis of dementia and had cognitive impairments. Further review of MDS, indicated R10 did not exhibit behaviors.<br><br>On 8/3/22, at 1:27 p.m. surveyor heard screaming coming from the day room. Surveyor observed R1 continuing to yell out in the day room while additional staff removed R6 from the day room. R6 was observed making comments such as she grabbed my arm and She hit me hard referring to R1.<br><br>On 8/3/22, at approximately 1:30 p.m. interview with trained medication assistance (TMA)-B stated R9 was attempting to sit behind R1 in the recliner when her walker bumped into R1 which caused R1 to hit R9 on her arm.<br><br>On 8/3/22, at approximately 1:30 p.m. health unit coordinator (HUC)-B confirmed she witnessed R1 slap R9 on her arm.<br><br>On 8/3/22, at 1:40 p.m. R1 was observed upset and yelling in the dayroom while speaking with social services (SS)-A. SS-A was observed leaving R1 in the day room as R1 continued to be upset. R1 was then observed to self-propel in her wheelchair to R10 who was sitting in his wheelchair in the day room and kicked his shin. TMA-B and registered nurse (RN)-A intervened and separated R1 and R10.<br><br>On 8/3/22, at 3:25 p.m. TMA-B stated staff were expected to report all resident to resident altercations to the charge nurse immediately. TMA-B confirmed she report both incidents involving R1 with R9 and R10 to the charge nurse RN-A, however was unsure if RN-A reported them to administrator.<br><br>On 8/1/22, at 12:36 p.m. during entrance conference with social services (SS)-A surveyor requested the facility's abuse policy which surveyor was provided a three page policy. On 8/2/22, at 9:50 a.m. surveyor inquired about additional parts to the abuse policy to the director of nursing (DON) who provided 5 additional pages to the abuse policy.<br><br>(continued on next page) |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, indicated all alleged violations involving abuse will be reported immediately but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury. In addition, facility policy indicates staff would protect residents during abuse investigations however the policy lacked clear guidance on the facility procedure for protection of residents. Facility policy did include upon receiving reports of physical or sexual abuse a licensed nurse or physician shall immediately examine the resident.<br><br>The policy lacked the following requirements for protection: increased supervision of the alleged victim and residents, room or staffing changes if necessary to protect the residents from the alleged perpetrator, protection from retaliation and providing emotional support and counseling to the resident during the investigation.<br><br>On 8/3/22, at 4:35 p.m. interview with both licensed practical nurse (LPN)-B and DON indicated staff were expected to report resident to resident altercations to the DON and SS-A upon ensuring safety of all residents involved in the incident. DON confirmed she was not aware of the two incidents involving R1 with R9 and R10 on 8/3/22.<br><br>On 8/4/22, at 2:05 p.m. SS-A indicated abuse investigations had been assigned to social services to complete. Further, SS-A indicated she was not trained on how to complete an investigation and was not aware of what the facility's policy was on protecting residents during an abuse investigation.<br><br>On 8/4/22, at 3:05 p.m. administrator the facility's policy directed staff to report incidents of abuse to the administrator or management within two hours. Administrator confirmed he was not aware of the two incidents involving R1, R9 and R10 until surveyor notified DON on 8/3/22. In addition, when asked what the facility's policy was regarding providing protection to the residents during an abuse investigation, Administrator stated, policy on protection is broad in the policy due to every incident is different you tailor the abuse protection to the person's needs and following an incident the interdisciplinary team (IDT) meets and will determine a plan that was tailored towards the incident. Further, administrator indicated the facility's policy are created by corporate who review the regulations and then the policy would be reviewed by the IDT at the facility when an incident occurs, or the facility needs clarification the facility would use the policy for guidance. Administrator confirmed the copy of the facility's abuse policy provided to the surveyor was the current policy, but Administrator wanted to check the system to ensure all parts of the policy were given. Surveyor did not receive anymore additional documents related to the facility's abuse policy. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on observation, interview, document review, the facility failed to report resident to resident physical abuse allegations timely to the Administrator of the facility and State Agency (SA) per regulation, within two hours, for 2 of 4 residents (R9, R10), who were reviewed for abuse from R1.<br><br>Findings include:<br><br>R1's annual minimal data set (MDS) dated [DATE], indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors.<br><br>R9's quarterly MDS dated [DATE], indicated R9 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R9 exhibited delusional behavior.<br><br>R10's quarterly MDS dated [DATE], indicated R10 had a diagnosis of dementia and had cognitive impairments. Further review of MDS, indicated R10 did not exhibit behaviors.<br><br>On 8/3/22, at 1:27 p.m. surveyor heard screaming coming from the day room. Surveyor observed R1 continuing to yell out in the day room while additional staff removed R6 from the day room. R6 was observed making comments such as she grabbed my arm and She hit me hard referring to R1.<br><br>On 8/3/22, at approximately 1:30 p.m. interview with trained medication assistance (TMA)-B stated R9 was attempting to sit behind R1 in the recliner when her walker bumped into R1 which caused R1 to hit R9 on her arm.<br><br>On 8/3/22, at approximately 1:30 p.m. health unit coordinator (HUC)-B confirmed she witnessed R1 slap R9 on her arm.<br><br>On 8/3/22, at 1:40 p.m. R1 was observed upset and yelling in the dayroom while speaking with social services (SS)-A. SS-A was observed leaving R1 in the day room as R1 continued to be upset. R1 was then observed to self-propel in her wheelchair to R10 who was sitting in his wheelchair in the day room and kicked his shin. TMA-B and registered nurse (RN)-A intervened and separated R1 and R10.<br><br>On 8/3/22, at 3:25 p.m. TMA-B stated staff were expected to report all resident to resident altercations to the charge nurse immediately. TMA-B confirmed she report both incidents involving R1 with R9 and R10 to the charge nurse RN-A, however was unsure if RN-A reported them to administrator.<br><br>On 8/3/22, at 4:35 p.m. interview with both licensed practical nurse (LPN)-B and director of nursing (DON) indicated staff were expected to report resident to resident altercations to the DON and SS-A upon ensuring safety of all residents involved in the incident. DON confirmed she was not aware of the two incidents involving R1 with R9 and R10 on 8/3/22.<br><br>On 8/4/22, at 3:05 p.m. administrator the facility's policy directed staff to report incidents of abuse to the administrator or management within two hours. Administrator confirmed he was not aware of the two incidents involving R1, R9 and R10 until surveyor notified DON on 8/3/22.<br><br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on record review no report was made to the SA within two hours or at time of exit.<br><br>Review of facility policy titled Abuse Investigation and Reporting dated 12/6/21, indicated all alleged violations involving abuse will be reported immediately but not later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury. |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080<br><br>Based on interview and document review, the facility failed to ensure residents identified at risk for worsening skin wounds received the necessary care and treatment to prevent the development of maggots in a wound for 1 or 1 residents (R6) who was hospitalized for a wound infestation. This resulted in harm for R6.<br><br>Findings include:<br><br>R6 was observed on 8/1/22, visiting with the nurses at the nurses station. A bandage on her left lower leg presented with signs of weeping yellow tinge coming through the bandage.<br><br>A Facility Reported Incident (FRI) submitted to the Stage Agency (SA) on 8/1/22, at 9:59 p.m. identified licensed staff who worked the 8/1/22 evening shift removed R6's dressing per her treatment orders and observed multiple maggots in wound bed secondary to date on dressing being approximately 3 (three) days old.<br><br>R6's Emergency Department Staff Physician Note dated 8/2/22, at 12:49 a.m. identified on exam R6's left lower extremity (LLE) showed evidence of necrotic appearing tissue and lacked larva/maggots on exam. The note indicated R6's family showed the provider a video with what appeared to be larva present particularly on the LLE. Due to R6's initial diagnosis of LLE wound and maggot infestation, R6 was admitted for intravenous (IV) antibiotics and wound care.<br><br>R6's Hospitalist Progress Note dated 8/4/22, identified IV antibiotics were stopped as infectious disease (ID) on 8/4/22, felt R6's LLE wounds were not infected. A wound care consult was ordered. Wound care consult notes were requested: none were provided.<br><br>R6's quarterly Minimum Data Set (MDS) dated [DATE], identified R6's cognitive status was not tested ; however, the MDS identified R6 was independent with mobility and daily cares. Diagnosis included cancer, dementia and mild cognitive impairment, diabetes insipidus (imbalance of water in the body), morbid obesity, anemia, and lymphedema (condition with swelling of legs or arms). In addition, the MDS identified R6 was free of ulcers, wounds, or skin problems; however, staff applied an ointment/medication to R6.<br><br>(continued on next page) |

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|---|---|
| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R6's Care Plan printed 8/9/22, identified R6 resisted treatments to her legs related to (r/t) confusion and provided examples of non-compliance: leg elevation, decreased fluid intake, and leg treatments. Interventions were identified as educating R6 of the possible outcome(s) of not complying with treatment or cares, encouraging her to participate as much as possible during cares, and giving clear explanation of all care activities prior to and as they occur during each contact. Further, R6's Care Plan identified on 6/7/22, R6 had an open area to her lower extremities related to increased edema and scratching the fragile skin. R6's goals were to be free from open lesions or injuries to her lower extremities, she would be free of complications to the open lesions, the open lesions would remain stable, and she would maintain or develop clean and intact skin by the review date. Interventions were to avoid scratching, educate her of causative factors and measures to prevent skin injury, encourage good nutrition and hydration to promote healthier skin, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry, use lotion to skin, report abnormalities to the provider, assistance to apply wraps ordered by physical therapy (PT) to bilateral extremities, and weekly treatment documentation. R6's Care Plan lacked evidence of individualized interventions which directed staff on actions, outside of verbal education and reminders, to attempt when R6 resisted wound care active and preventative treatments.<br><br>Vohra Wound Physicians Initial Wound Evaluation and Management Summary, dated 6/7/22, identified R6 was examined to have one lymphademic wound (full thickness) to her right leg (1 cm (centimeter - length) x 1.4cm (width); 1.40cm surface area (length x width); 100 percent (%) granulation (sign of healing) tissue) and one to her left leg (2.8cm x 1.3cm; 90% slough (dead skin tissue). Initial provider orders were as follows:<br><br>-Xeroform sterile gauze covered by a Kerlix dressing (to both legs) QD (every day). R6's TARs (treatment administration record(s) dated 6/7/22 - 8/1/22, directed staff to cleanse the back of R6's left leg and apply a dry dressing BID (twice a day) before ace wraps were applied; however the MARs/TARs lacked the QD Xeroform/Kerlix order to both legs and lacked evidence of any directed wound care order to R6's right leg.<br><br>-Recommendation was provided to elevate leg(s). R6's MARs/TARs dated 6/7/22 - 8/1/22 directed staff to encourage R6 to elevate her legs while lying in bed and lacked directions for leg elevation at other times.<br><br>Subsequent [NAME] visits identified the following information (wound care orders and recommended leg elevation remained unchanged from the 6/7/22 order unless indicated):<br><br>-6/14/22: Right leg wound progress deteriorated (2cm x 6cm; 12cm surface area; 80% slough, and 20% granulation tissue) and the left leg improved.<br><br>-6/24/22: Right leg wound progress improved and the left leg remained unchanged. An order was provided for PT (physical therapy) to evaluate for multilayer compression wraps for lymphedema. R6's medical record lacked evidence of the PT order or that PT was updated to the order.<br><br>-7/5/22: Right leg wound progress showed the wound resolved. The left leg (1cm x 0.5cm; 0.50cm surface area; 5% slough; 95% granulation) wound progress improved.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -7/12/22: Left leg wound progress deteriorated (18cm x 36cm; 648cm surface area; 5% slough; 95% granulation). In response, Aquaphor was ordered to be applied QD to the periwound (outside edges of the wound). In addition, the dictation indicated an initial evaluation of a full thickness lymphademic wound of R6's right leg was completed (9cm x 8cm; 72cm surface area, 100% granulation tissue) with an associated procedure note: This wound has previously undergone autolytic debridement. In response, Xeroform sterile gauze covered by a Kerlix dressing and Aquaphor applied periwound QD was ordered. R6's TARs dated 7/12/22 - 8/1/22, directed staff to apply Aquaphor ointment to R6's lower leg/extremities BID and PRN (as needed); however, the TARs lacked evidence of the 7/12/22 Aquaphor directed left leg periwound order. In addition, the MARs/TARs dated 7/12/22-8/1/22, lacked evidence staff were directed to provide, or provided, the Xeroform/Kerlix order to R6's right leg wound.<br><br>-7/19/22: Left leg (4.6cm x 1cm; 4.6cm surface area; 5% slough) and right leg (1.6cm x 0.7cm; 1.12cm surface area; 100% granulation) wound progresses improved.<br><br>-7/26/22: Left leg (12cm x 5cm; 60cm surface area; 90% slough; 10% granulation) and right leg (1.4cm x 1. 6cm; 2.24 cm surface area; 100% granulation) wound progresses deteriorated. In response, Santyl (enzymatic debridement agent) was ordered QD to be applied to both wounds. R6's MARs/TARs dated 7/26/22 - 8/1/22, lacked evidence staff were directed to apply, or applied, Santyl to R6's bilateral leg wounds.<br><br>R6's 6/1/22 - 8/1/22 MARs/TARs, identified the following additional skin/wound care treatments:<br><br>-TAR: Ace wraps on every morning and removed at bedtime for edema (fluid in the legs), in which they were to be applied at 8:00 a.m.<br><br>-TAR: Lymphedema wraps to lower extremities QD which were directed to be applied at 8:00 a.m.<br><br>-TAR: If R6 refused lymphedema wraps, start TED (compression socks decrease blood clots) stockings instead every shift.<br><br>R6's Skin and Wound Evaluation V5 dated 6/7/22, identified R6 had a new open lesion. The location box remained blank. The evaluation identified R6 experienced increased edema to her lower extremities which caused her to scratch at the area causing it to open. PT worked with R6 to control the fluid build-up. Nursing initiated an order to apply Aquiform to the area twice daily (BID) to help minimize the itching. In addition, staff encouraged R6's compliance with set up treatments and lower extremity wraps, to sleep in her bed and to not scratch at her legs (right leg font skin area).<br><br>R6's Skin and Wound Evaluation V5.0 dated 7/12/22, identified R6 had a new open lesion. The location box remained blank. The evaluation identified R6's wound was slow to heal as R6 kept removing the dressing to scratch at the area. The wound dressing order remained the same. In addition, R6 was educated on the importance of keeping the dressing intact and to avoid scratching the wounds.<br><br>R6's Skin and Wound Evaluation V5.0 dated 7/19/22, identified R6 had a new left shin open lesion. The evaluation identified R6's wound status was stable; however, the wound was at risk for deteriorating as R6 continuously scratched and removed the dressing. The wound dressing order remained the same. In addition, R6 was educated to not scratch the wound and not to remove the wound dressing.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R6's Skin and Wound Evaluation V5.0 dated 7/26/22, identified R6 had a new left shin open lesion. The evaluation identified R6's wound progress stalled and R6 continued to scratch the wound and remove the dressing herself. Wound dressing stayed the same. In addition, R6 was educated on the importance of not scratching to allow proper healing of the wound and advised to allow the dressing to remain in place.<br><br>A subsequent Skin and Wound Evaluation V5.0 dated 7/26/22, identified R6 had a right shin rash which was slow to heal. The evaluation was uncompleted.<br><br>R6's progress notes identified the following entries:<br><br>-5/31/22: R6 was observed to have an open area at the back of her left leg.<br><br>-6/7/22: R6 was alert to self with confusion. She was seen by the wound doctor and no changes were made on her treatment orders.<br><br>-6/28/22: R6 was not assessed during wound rounds secondary to her being non-compliant at time of rounds.<br><br>-7/14/22: R6 was confused and both feet are open and weepy, washed with soap and water and then cleanser, Xeroform applied and wrapped with calyx.<br><br>-8/1/22, at 1:21 p.m. R6 was noncompliant with her dressing change treatment. The incoming nurse was notified of [R6's] non cooperation to try and change the wounds at the end of the shift.<br><br>-8/1/22, at 10:09 p.m. R6's daughter was updated related to R6's complicated impaired wound bed.<br><br>-8/1/22, at 10:14 p.m. R6's on-call provider updated on wound status and provided an order to send R6 to the emergency room to evaluate and treat her bilateral wound extremities.<br><br>8/1/22, at 11:54 p.m. R6 was alert and oriented to self with some confusion. Her bilateral wounds on her feet were severely affected [sic] and multiple maggots were presenting from the wounds. At 11:10 p.m. R6 was sent to the hospital.<br><br>R6's progress notes, dated 7/27/22 - 8/1/22, at 1:21 p.m. lacked evidence R6 refused wound care treatments or that on 7/27/22, R6's family completed the dressing change.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | When interviewed on 8/4/22, at 3:15 p.m. LPN-E stated she worked with R6 on the evening of 8/1/22, and provided her wound treatments. She explained the day nurse updated her R6 refused her day shift dressing change and asked LPN-E to complete it. That evening LPN-E started to encourage R6 to return to her room around 7:30 p.m., as she refused her shower despite multiple attempts that shift, in order for her to at least complete R6's dressing change. It took R6 two hours before she complied. When LPN-E opened the left leg wound dressing, she stated, I realized it was infected. The maggots started coming out . LPN-E confirmed she did not count the maggots as they just dropped on the floor; however, stated there were more than one but not 10 of them, and she described them as white in color and about a centimeter long. LPN-E stated the wound was not draining and the dressing was not clean; however, she described the dressing as if had lotion or Vaseline on it which then picked up debris when R6 rubbed up against things and it stuck to the dressing. She added because R6 preferred to wear dresses, the dressings were exposed and got dirty. Lastly, LPN-E stated she did not recall if there was a date on the dressing when she removed it.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During a telephone interview on 8/5/22, at 8:46 a.m. the wound care physician (WCP) stated she provided weekly resident wound care rounds in which rounds consisted typically of the nurse manager (LPN)-B, a nurse if available, and then a nursing assistant (NA) would follow when first floor wound rounds were conducted. She explained staff prepare the residents for her visit in which either she or the staff removed the old dressings. She then examined and assessed the wounds in which LPN-B took notes related to suggested wound care treatment changes and/or recommendations. Once the visit was over, the nurse would complete the ordered treatment. She confirmed she did not review each resident's medical record (progress notes/MAR/TAR) during each visit to review the orders and to ensure her orders were being carried out as she prescribed. She explained that was the facility's responsibility. She stated when she observed something [dressing] missing she inquired if the order was on the MAR/TAR. The WCP confirmed she observed probably one or two patients every week with incorrectly performed wound care treatments which she stated was more common if I changed the dressing the previous visit. She continued there were times when there was a lag on getting the dressing that I ordered .I am not sure what happens. She acknowledged there were also times when she was required to inquire as to the whereabouts of an ordered dressing or the Santyl. She stated, It has been an ongoing process to fix it [supply issues]. She responded she generally is not updated on facility issues related to order clarification requests and/or issues related to obtaining ordered treatment supplies. She typically found out about concerns when she returned to the facility the following week. The WCP verbalized she had spoken to the DON about her concerns; however, she had not drilled down to find out the reasons for the concerns: It would seem there should be a uniform process. When the WCP ordered wound treatments she had specific thoughts in mind and rationalizations as to why she chose, or did not choose, a particular treatment. She explained if a resident was provided wound care treatment(s) she did not order, the treatment error would make it more difficult for her to evaluate and assess the wound: It slows down the evaluation process and the wound may show a failure to progress. The wound may also decline and/or the wound may develop moisture associated skin damage if staff failed to provide a barrier cream. The WCP stated her dictated progress notes, with updated orders, were available to the staff the same day as the wound rounds in which she expected the staff to review the dictation for any order or recommendation adjustments. and/or the need for any clarifications. and then process her orders and recommendations as written. The WCP stated, .in general they are trying very hard and it seems they need some guidance on the process. It is not just measuring the wounds .the orders need to be in and done correctly. Supplies need to be in the facility and in the room and they may need some process changes or at least to look at that process. The WCP stated during wound rounds on 7/26/22, R6's wound was assessed to have deteriorated; however, the wound was free from signs and symptoms of infection or maggots. She was unable to comment on information related to maggots in a wound; however, she did not feel that the application of incorrect dressings would have caused them. She explained she had reviewed some literature and read maggots were not a hygiene concern, but a fly issue. She stated she had not observed R6's dressings off when she visited and did not have issues with dirty dressings; however, she commented, If [staff] were covering [the legs] and the dressings were on, it is hard to say that it led to the maggots. The WCP stated with the 7/26/22 rounds, R6's legs looked wetter and thus she ordered the Santyl to debride them. She again stated she expected staff to process her orders and follow them as directed. When the WCP was questioned about R6's therapy order, she confirmed she did not know if the recommendation was completed: I would have expected it to be done or an explanation [as to why not completed]. She acknowledged she was not aware R6 worked with PT since she started wound rounds with her.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | When interviewed on 8/5/22, at 1:08 p.m. R6's FM-B stated when she arrived on 7/27/22, R6 lacked dressings to her legs as R6 sat in the day room. The legs were oozing clear liquid and bleeding profusely. FM-B explained she walked her back to her room and she provided wound care to R6's legs. She cleansed the wounds with wound cleaner and wrapped the legs with gauze after she sterilized everything and used gloves. FM-B stated she had attempted to ask the nurse to apply dressings to R6's legs; however, she explained they were getting him to work somewhere else. FM-B stated she had not visited with R6 between the time she changed her dressings on 7/27/22 and when she arrived back to the facility on [DATE].<br><br>During interview on 8/5/22, at 2:05 p.m. LPN-C stated when an order was received the health unit coordinator (HUC) initially entered the order into the MAR/TAR. After, a nurse performed a double check. LPN-C explained wound care provider orders were processed like any other doctor. He confirmed orders were expected to be processed exactly how the order was written by the provider and the order was expected to be followed. LPN-C stated if orders were not processed or followed risks to the residents may occur: It would depend on what the error was. He provided a verbal example in which during dressing changes he had personally observed an ABD or a Mepilex on a resident; however, upon his review of the MAR/TAR, these types of dressings were not the active order. LPN-C explained if the wrong dressing or treatment was observed, he reviewed the MAR/TAR and it was not his overall practice to review the actual provider order. LPN-C acknowledged discussions with the nurse manager about such concerns and other medication order process concerns and verbalized he was not involved in the weekly wound round process. He verbalized R6's dressings came off at night and in the morning she would not have dressings on [based on R6's wound care orders, her wounds would always be covered]. LPN-C confirmed on the morning of 7/27/22, he observed R6 without dressings on her legs and her legs were bleeding. On 7/27/22, around lunch time, FM-B approached him after they arrived and asked if he could apply R6's dressings. He stated he informed FM-B he needed to address another resident's concern at that moment. Around 11:00 a.m. LPN-C observed Kerlix on R6's legs and he learned FM-B had applied it. LPN-C stated as soon as FM-B left the facility, he assisted R6 back to her room and re-applied the ordered dressings. He confirmed FM-B applied just plain gauze dressing. LPN-C denied he dated the dressing on 7/27/22; however, he acknowledged he should have dated the dressing and he should have documented that days dressing change status.<br><br>When interviewed on 8/5/22, at 2:50 p.m. the evening nurse supervisor (LPN)-D stated when she received orders or order changes she processed them and then the order was double checked by another nurse. She expected the order to be processed as written and if the nurse questioned the order the provider was to be updated for clarifications. Further, she expected the nurses to follow the orders as prescribed. LPN-D confirmed Adaptic and Xeroform were not the same dressing and expected to see Xeroform on a wound if that was the dressing ordered and not Adaptic. She explained if a wound care order was not followed as prescribed, That might cause the wound to deteriorate. She confirmed she was unaware of any current concerns related to staff not following provider orders or nurses finding non-ordered dressings on residents. Further, she confirmed she was not aware of any wound treatment supply issues. LPN-D acknowledged she observed R6's leg on 7/27/22, and witnessed multiple maggots. She denied she had observed a date on R6's dressing that evening and explained the dressing was dry and a brownish dark color was on the inside of the dressing. She denied the wound had any odor and reported it really did not look different from the last time she had observed it.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 8/5/22, at 3:15 p.m. the director of rehab (DOR) and physical therapist (PT)-A were interviewed together. The DOR reviewed R6's therapy notes and confirmed therapy was not updated on the WCP's 6/24/22, therapy orders; however, she explained R6 was involved with therapy from 5/2/22 through 7/22/22. PT-A stated he was not involved in R6's wound care; however, he provided her with full body lymphedema treatment and he worked with her on lymphedema wraps. He acknowledged R6 only allowed them for very short periods of time and then she made attempts to remove them herself. The DOR stated she would expect nursing staff to update her related to any provider orders for therapy, even if they already worked with the resident, to ensure what was ordered was already part of the resident's treatment plan.<br><br>When interviewed on 8/9/22, at 11:49 a.m. LPN-B stated he started the nurse manager role in May (approximately two months prior). He explained during wound rounds he took notes based on comments provided by the WCP, and once the WCP completed her dictated reports, he reviewed them and ensured the orders in the MAR/TAR were updated and/or current. He explained he or the nurses could process the WCP orders and stated he expected the order for the WCP and the order entered into the MAR/TAR were exact. He confirmed all orders were expected to be double checked and co-signed on the order sheet and then the HUC would scan the order into the medical record. LPN-B stated the WCP did not send regular orders and they just get scanned in. He confirmed he did not co-sign the WCP orders or that he asked another nurse to double check the orders; however, if another nurse was to process the WCP orders, he expected them to have another nurse co-sign them. He stated processing and following the WCP orders were expected and were important to help minimize the risk of the wound getting out of hand such as infection or decreased healing. He acknowledged he printed out the orders and went through them one at a time to check them for accuracy and indicated it was a lot for one person. In addition, he acknowledged he lacked any observations the wrong dressings or treatments were provided to residents. He confirmed the facility experienced no recent order supply concerns. LPN-B stated he performed R6's dressing change on 7/30/22, in which he did not observe any concerns. He explained R6 took her dressings off herself and staff could change her dressings and there was no guarantee it is going to stay there. That is why there is a two times day dressing changes. He acknowledged he expected nurses to place a dressing on R6's legs as directed, if R6's legs lacked a dressing. He explained the dressings served a purpose of helping to improve healing and to decrease edema. LPN-B stated R6 had not declined dressing changes for him and he was unaware she declined them for other nurses. When LPN-B was questioned on Adaptic or Xeroform dressings, he was unable to answer if they were the same dressing or different; however, he stated, What is in the MAR and TAR is what is expected to follow. If staff have questions they can reference the orders from the doctor.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During interview on 8/9/22, at 1:39 p.m. the DON stated the WCP dictated notes and orders did not come the traditional way as other provider orders were received. She confirmed the WCP dictation and orders were available for review within 24 hours in which nurse management and leadership was responsible to make sure the orders were updated, current, and processed as wrote by the WCP. In addition, she expected staff to follow the order as prescribed and if there were concerns identified with the order, the provider was to be contacted for clarification. The DON stated if staff failed to follow an order as prescribed staff were not doing what they were expected to do, which could cause a wound infection. The DON stated during a conversation with R6's FM-B on 8/1/22, FM-B changed R6's dressings on 7/27/22. Staff failed to notify her of this incident. In addition, FM-B informed her no one had changed R6's dressings since. The DON explained during her investigation into R6's wound being found with maggots the dressings were changed by staff despite FM-B's statements they had not. When the DON was questioned as to why the 8/1/22, FRI indicated the dressing was not changed for three days, she explained she panicked and took FM-B's initial statements into account and I thought the worst. The DON confirmed Adaptic and Xeroform are different dressings in which Xeroform is more medicated. She explained a lot of their seasoned nurses have left which may be one reason for some of the wound care/dressing concerns. She stated, when she first started in April, there were definite education issues and she commented it appeared as if they needed to have the wound care supply representative out to the facility for staff training.<br><br>A policy for physician order processing and transcription was requested. An undated policy Medication and Treatment Orders was provided and identified the policy's purpose was for medication and treatment orders to be consistent with principles of safe and effective order writing. The policy identified drug and biological orders were to be recorded on the Physician's Order Sheet in the resident's chart. The policy lacked direction on the facility's process for nurse order processing and transcription or expectations related to medication and/or treatment administration.<br><br>An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice.<br><br>43083 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080<br><br>Based on interview and document review, the facility failed to ensure residents identified at risk for worsening pressure ulcers received the necessary care and treatment to decrease the risk of worsening wounds and decreased healing for 1 of 1 residents (R7) who in the sample of residents was identified to have a pressure ulcer and who followed the rounding wound care physician.<br><br>Findings include:<br><br>R7's hospital History and Physical, dated 12/3/21, identified R7 presented to the hospital with a sacral decubitus (pressure) ulcer.<br><br>R7's quarterly Minimum Data Set (MDS), dated [DATE], identified R7 was severely cognitive impaired and was free of exhibited rejection of care(s). She required extensive physical assist for mobility and cares and experienced total bladder and bowel incontinence. Diagnosis included dementia, morbid obesity, weakness, and a sacral region pressure ulcer. In addition, the MDS identified R7 was at risk for pressure ulcers based on formalized and clinical assessments in which R7 presented with a stage 4 pressure ulcer and pressure ulcer care.<br><br>R7's Care Plan, printed 8/9/22, identified R7 was dependent on staff for .intellectual, physical .needs r/t (related to) cognitive deficits, immobility, and physical limitations. Her ADL (activities of daily living) care needs directed staff to use extensive assistance to assist R7 to turn and reposition in bed and her Care Plan identified R7 presented with a stage 4 pressure ulcer on her coccyx r/t immobility. Interventions included the following: administer treatments as ordered and monitor for effectiveness, avoid positioning on coccyx for extended periods of time, encourage and assist to shift weight in wheelchair every 15 minutes, if treatments refused, confer with her, IDT (interdisciplinary team), and family to determine why and to try alternative methods, assist to turn/reposition at least every two hours, more often as needed or requested.<br><br>Vohra Wound Physicians Initial Wound Evaluation and Management Summary, dated 1/4/22, identified R7 was examined to have a stage 4 sacral pressure ulcer (6cm (centimiters -length) x 5cm (width) x 3cm (depth); 30cm surface area (length x width); 10% slough (dead tissue); 90% granulation (signs of healing tissue). Initial provider orders were as follows:<br><br>-Leptospermum Honey [Medihoney] BID (twice a day) applied to the wound base.<br><br>-Alginate Calcium (dressing) BID<br><br>-Gauze Roll (Kerlix) BID - pack remainder of wound with fluffed Kerlix and cover with a foam border dressing.<br>R7's MAR/TAR (medication/treatment administration record(s) dated 1/4/22 - 4/19/22, lacked evidence staff were directed to pack the wound with fluffed Kerlix. In addition, her MAR/TAR dated 1/4/22 - 4/19/22, indicated a PRN (as needed) order for coccyx wound dressing changes; however, the orders from 1/4/22 - 8/4/22 lack evidence of a PRN order.<br><br>Subsequent [NAME] visits identified the following information:<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -1/18/22: the wound progress improved. During the visit she was initially evaluated to have diagnosis of lichenification and Moisturizer to areas of dry skin daily was ordered. R7's MAR/TAR dated 1/18/22 - 8/4/22, lacked evidence the moisturizer order was initiated.<br><br>-1/25/22: the wound progress remained unchanged (5cm x 4cm x 2cm; 20cm surface area with undermining 1.5cm at three o'clock, 5% necrotic (hard dead tissue); 5% slough (dead tissue) 90% granulation). A purplish discoloration of left side of wound bed was observed and the provider recommended [R7] to rest more on right side to alleviate pressure on left side of wound. R7's MAR/TAR dated 1/25/22 - 8/4/22, directed staff to turn and reposition R7 every two hours and lacked evidence of the order to rest more on her right side.<br><br>-3/10/22: the wound progress deteriorated (5cm x 4cm x 3cm; 10cm surface area; 60% granulation; 40% other viable tissues 40% muscle) due to patient non-compliant with wound care. The provider recommended limit sitting to one hour up in chair or wheelchair, then one hour of resting on side. R7's MAR/TAR dated 3/10/22 - 8/4/22, lacked evidence the order was initiated.<br><br>-4/5/22: the wound progress improved.<br><br>-4/19/22: the wound progress remained unchanged (4cm x 3cm x 2cm; 12cm surface area; 20% slough; 40% granulation; 40% muscle); however, an order was provided for Santyl (enzymatic debriding agent) once a day (QD) to be applied to the wound after the wound was cleansed with wound cleanser. The Alginate Calcium order continued for BID. The honey application was discontinued. R7's MAR/TAR dated 4/19/22 - 8/4/22 directed staff to apply Santyl after the wound was cleansed and then to cover with calcium alginate, pack with Kerlix, and cover with an ABD (high absorbency) dressing and tape BID; however, the MAR/TAR lacked evidence of the once a day Santyl application was initiated. In addition, R7's medical record/wound care orders continued to direct a foam border dressing and she lacked an order for ABD dressing and tape. Furthermore, the MAR/TAR indicated the Medihoney order ended on 4/22/22, not as ordered on 4/19/22.<br><br>-4/26/22: the wound progress deteriorated (5cm x 2.7cm x 2cm; 13.5cm surface area; 60% slough; 20% granulation; 20% muscle) and the Alginate Calcium, Kerlix, and foam border dressing order was changed to an QD application (the BID order was discontinued). An Additional Wound Detail note indicated the DON will review dressing application with nursing. R7's MAR/TAR dated 4/26/22 - 8/4/22, directed BID wound care dressing changes and lacked evidence the order was changed to QD.<br><br>-5/3/22: the wound progress remained unchanged. An Additional Wound Detail note indicated Application of Santyl demonstrated to nursing.<br><br>-5/17/22: the wound progress improved (4.5cm x 3.7cm x 2cm; 16.65cm surface area; continued undermining; 30% slough; 50% granulation; 20% muscle; however, an order for house barrier cream to be applied around the wound perimeter QD was provided. R7's MAR/TAR dated 5/17/22 - 8/4/22 lacked evidence of a barrier cream order.<br><br>-6/7/22: the wound progress deteriorated (5.9cm x 4.7cm x 1.5cm; 27.73cm surface area; continued undermining; 20% slough; 60% granulation; 20% muscle).<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -6/14/22: the wound progress improved. On 6/14/22, R7's MAR/TAR was updated and directed staff to utilize skin prep to the wound edges before the ABD was applied. R7's wound care orders or medical record lacked evidence of a skin prep order and/or the use of an ABD.<br><br>-7/5/22: the wound progress remained unchanged.<br><br>-7/12/22: the wound progress remained unchanged. Negative pressure wound therapy (VAC) was ordered to be applied three times per week. The Alginate Calcium, Kerlix, Santyl and foam border were discontinued. R7's MAR/TAR dated 7/12/22, lacked evidence of a VAC order or that the Santyl and dressings were stopped.<br><br>-7/19/22: the wound progress remained unchanged (4cm x 5.4cm x 1cm; 21.60cm surface area; 1.5cm continued undermining; 20% slough; 60% granulation; 20% muscle. The VAC order continued. An Additional Wound Detail note indicated Wound VAC not yet available. No additional wound care orders were provided.<br><br>-7/26/22: the wound progress improved. An Additional Wound Detail note indicated Wound VAC not yet in place. DON has been asked to facilitate. No additional wound care orders were provided.<br><br>-8/2/22: the wound progress improved (5cm x 3.7cm x 1cm; 18.50cm surface area; 1.5cm continued undermining; 10% slough; 70% granulation; 20% muscle). An Additional Wound Detail note indicated [R7] did not tolerate wound VAC. Periwound erythema developed with VAC. Tx (treatment) now with barrier cream. VAC orders continued; however, Alginate Calcium, Santyl, and a superabsorbent silicone border dressing once a day was ordered. R7's MAR/TAR dated 8/2/22 - 8/4/22 lacked evidence of the new order or the barrier cream.<br><br>From 7/12/22 - 8/4/22, R7's MAR/TAR lacked evidence the VAC was initiated and continued to direct staff to apply Santyl and the dressings BID. Her medical record lacked evidence the wound care physician (WCP) was updated between wound care rounds related to any VAC complications or to question the need for continued dressing order(s) until the VAC could be initiated.<br><br>R7's progress notes identified the following entries:<br><br>-5/10/22: [R7] seen by Wound Dr and noted that incorrect alginate being used with Santyl. Licensed staff and Writer [DON] replaced incorrect treatment dressing in designated wound bucket .<br><br>-5/10/22: [DON] has updated wound treatment to include the following: calcium should not be cut and box removed from should be green. If not in wound supplies in [R7's] room alert DON and/or facility leadership prior to completing dressing change.<br><br>-From 7/12/22 - 7/28/22, R7's progress notes lacked evidence a VAC was discussed with R7 or family, was ordered, was applied, and/or a rationalization as to why the VAC order was not initiated on 7/12/22 with initial order or on 7/19/22 and 7/26/22 with the continued VAC orders. In addition, the progress notes lacked evidence the wound care provider was updated related to the VAC directed orders not being initiated or performed.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -7/29/22 (a late entry recorded on 8/3/22): A wound VAC was applied as per the wound doctor order. Resident initially complained of the wound vac being uncomfortable. Resident will continue to be monitored and subsequent changes will be to provide resident more comfort.<br><br>-From 7/29/22 - 8/2/22: R7's progress note lacked documentation related to the VAC.<br><br>-8/3/22: her bottom is red in patches some from the tape removal. The wound edges are whitish and the skin is pealing [sic] off in some areas. [R7] has an order for negative pressure therapy but the wound vac is missing, and so the writer did Santyl and silver alginate and ABD was used, the DON, nurse manager and family were notified. The management will call the wound doc for new orders till the wound vac issue is resolved. In coming nurse was updated. [on 8/2/22 wound care provider was updated (per her dictation) that R7 did not tolerate the VAC and she provided new orders for Alginate Calcium, Santyl and a superabsorbent silicone border dressing QD].<br><br>-From 8/3/22 - 8/9/22, R7's progress notes lack evidence the wound care provider was updated related to R7's 8/3/22 progress note and/or to obtain an order to officially discontinue the 8/2/22 continued VAC order.<br><br>-8/4/22: [DON has reached out to Custom Medical regarding the following inquiry: Was wound vac picked up not showing up in here to reflect she has one here. It has been discontinued by the Dr per family request; response pending.<br><br>-From 8/4/22 - 8/9/22, R7's progress notes lacked evidence the VAC was found or discontinued.<br><br>When interviewed on 8/4/22, at 3:15 p.m. LPN-E stated she was responsible for processing orders and explained either the health unit coordinator (HUC) or a nurse initially processed the order and then a nurse was required to double check it. She stated once staff completed the order process, they were required to sign the order to verify it was completed. LPN-E denied she processed orders from the WCP and was unsure as to the orders process when the WCP completed wound rounds on Tuesdays. She confirmed nurses were expected to follow what the MAR/TAR directed and if there were concerns, they were expected to update the provider for clarification. LPN-E acknowledged a first floor resident recently received VAC treatment; however, she was unaware of any residents on other floors that received recent VAC orders. She stated R7 required a dressing change every evening. She was unsure as to what R7's day shift orders were. She stated she was unaware R7 was recently ordered to try a VAC and R7 was ordered for every two hour repositioning. LPN-E explained R7 propelled herself around the unit with her wheelchair and was compliant with the every two hour repositioning; however, she commented R7 was often in her wheelchair during the evening shift and staff attempted to encourage her to lay down right after supper: If she is ready. She denied R7 took naps or laid in bed during the evening shift when she worked.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephone interview on 8/5/22, at 8:46 a.m. WCP stated she provided weekly resident wound care rounds in which rounds consisted typically of the nurse manager (LPN)-B, a nurse if available, and then a nursing assistant (NA) would follow when first floor wound rounds were conducted. She explained staff prepare the residents for her visit in which either she or the staff removed the old dressings. She then examined and assessed the wounds in which LPN-B took notes related to suggested wound care treatment changes and/or recommendations. Once the visit was over, the nurse would complete the ordered treatment. She confirmed she did not review each resident's medical record (progress notes/MAR/TAR) during each visit to review the orders and to ensure her orders were being carried out as she prescribed. She explained that was the facility's responsibility. She stated when she observed something [dressing] missing she inquired if the order was on the MAR/TAR. The WCP confirmed she observed probably one or two patients every week with incorrectly performed wound care treatments which she stated was more common if I changed the dressing the previous visit. She continued there were times when there was a lag on getting the dressing that I ordered .I am not sure what happens. She acknowledged there were also times when she was required to inquire as to the whereabouts of an ordered dressing or the Santyl. She stated it has been an ongoing process to fix it [supply issues]. She responded she generally is not updated on facility issues related to order clarification requests and/or issues related to obtaining ordered treatment supplies. She typically found out about concerns when she returned to the facility the following week. The WCP verbalized she had spoken to the DON about her concerns; however, she had not drilled down to find out the reasons for the concerns: It would seem there should be a uniform process. When the WCP ordered wound treatments she had specific thoughts in mind and rationalizations as to why she choose, or did not choose, a particular treatment. She explained if a resident was provided wound care treatment(s) she did not order, the treatment error would make it more difficult for her to evaluate and assess the wound: It slows down the evaluation process and the wound may show a failure to progress. The wound may also decline and/or the wound may develop moisture associated skin damage if staff failed to provide a barrier cream. The WCP stated her dictated progress notes, with updated orders, were available to the staff the same day as the wound rounds in which she expected the staff to review the dictation for any order or recommendation adjustments. and/or the need for any clarifications. and then process her orders and recommendations as written. The WCP stated .in general they are trying very hard and it seems they need some guidance on the process. It is not just measuring the wounds .the orders need to be in and done correctly. Supplies need to be in the facility and in the room and they may need some process changes or at least to look at that process. The WCP stated R7's sacral ulcer kind of plateaued and she started to develop slough in the wound so she ordered Santyl. She explained R7 had utilized a VAC upon admission; however, at that time she failed to tolerate the treatment and it was discontinued; however, when R7's wound started to produce less drainage and appeared to be getting smaller in size, with R7 experiencing decreased complaints of wound pain and increased ability to assist with bed mobility, the WCP discussed with R7's husband reapplying the VAC. She explained the VAC was not in place when she returned for wound rounds the following week after she initially ordered it. She stated staff informed her the DON wished to have a conversation with R7's husband as the DON was told by staff he did not want the VAC placed on R7. The WCP asked staff to double check on that information and informed the staff the husband had okayed a trial use of the VAC with her conversation, and if R7 did not tolerate, they would discontinue it. The week following, the WCP did not observe the VAC in place and she stated she was informed the facility did not have the VAC. She explained she emailed the DON and she was informed by facility staff someone was going to order it. With her most recent visit on 8/2/22, she stated staff informed her staff applied the VAC to R7; however, she did not tolerate it. The WCP confirmed she did not review R7's medical record after she ordered the VAC to determine if her orders for R7 were followed. She explained, I would have a low bar for making [R7] use [the VAC] but I thought she might be fine if they bridged it .her wound has stalled out and it is a deeper wound, and a wound that if we had this, someone would put a VAC on it to bring it together. Further, she explained she ordered the VAC as R7's husband indicated he was attempting to discharge R7 to another facility to be closer to him and she felt this would help facilitate such a move as the treatment would only be three times a week, not daily. The WCP, when questioned on her expectations for recommendations, confirmed the recommendations were to be treated as orders and were to be processed as such. She confirmed her |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During interview on 8/5/22, at 2:05 p.m. LPN-C stated when an order was received the health unit coordinator (HUC) initially entered the order into the MAR/TAR. After, a nurse performed a double check. LPN-C explained wound care provider orders were processed like any other doctor. He confirmed orders were expected to be processed exactly how the order was wrote by the provider and the order was expected to be followed. LPN-C stated if orders were not processed or followed risks to the residents may occur: It would depend on what the error was. He provided a verbal example in which during dressing changes he had personally observed an ABD or a Mepilex on a resident; however, upon his review of the MAR/TAR, these types of dressings were not the active order. LPN-C explained if the wrong dressing or treatment was observed, he reviewed the MAR/TAR and it was not his overall practice to review the actual provider order. LPN-C acknowledged discussions with the nurse manager about such concerns and other medication order process concerns and verbalized he was not involved in the weekly wound round process.<br><br>When interviewed on 8/5/22, at 2:50 p.m. the evening nurse supervisor (LPN)-D stated when she received orders or order changes she processed them and then the order was double checked by another nurse. She expected the order to be processed as wrote and if the nurse questioned the order the provider was to be updated for clarifications. Further, she expected the nurses to follow the orders as prescribed. She explained, if a wound care order was not followed as prescribed, That might cause the wound to deteriorate. She confirmed she was unaware of any current concerns related to staff not following provider orders or nurses finding non-ordered dressings on residents. Further, she confirmed she was not aware of any wound treatment supply issues. She denied knowledge of any residents recently being ordered a VAC and/or issues obtaining a VAC if one were ordered. She acknowledged if a VAC order was not processed, for any reason, the provider was to be updated for additional orders until the VAC situation was fixed.<br><br>During a telephone interview on 8/9/22, at 10:24 a.m. R7's family member (FM)-A stated he had issues with R7's wound care. He explained staff do not follow the physician orders and reported he had observed her wound to be open and no dressings in place. He acknowledged this happened maybe three times in the seven months she has been there. He verbalized this concern improved after the last time and his conversation with the WCP when he updated her on his concerns and she informed him she would talk to someone; however, he expressed his frustration related to R7's recent VAC order. He explained he conversed with the WCP the last three weeks related to the VAC and he confirmed he initially agreed for R7 to attempt the VAC again for a little while to see if it can get it to close a little quicker and if R7 did not tolerate it, the VAC would be discontinued. FM-A stated he visited R7 at a minimum three days a week and he confirmed he did not observe the VAC on R7's wound and further confirmed the staff did not talk with him about any attempted application of the VAC and/or if they did how R7 tolerated it.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | When interviewed on 8/9/22, at 11:49 a.m. LPN-B stated he started the nurse manager role in May (approximately two months prior). He explained during wound rounds he took notes based on comments provided by the WCP, and once the WCP completed her dictated reports, he reviewed them and ensured the orders in the MAR/TAR were updated and/or current. He explained he or the nurses could process the WCP orders and stated he expected the order for the WCP and the order entered into the MAR/TAR were exact. He confirmed all orders were expected to be double checked and co-signed on the order sheet and then the HUC would scan the order into the medical record. LPN-B stated the WCP did not send regular orders and they just get scanned in. He confirmed he did not co-sign the WCP orders or that he asked another nurse to double check the orders; however, if another nurse was to process the WCP orders, he expected them to have another nurse co-sign them. He stated processing and following the WCP orders were expected and were important to help minimize the risk of the wound getting out of hand such as infection or decreased healing. He acknowledged he printed out the orders and went through them one at a time to check them for accuracy and indicated it was a lot for one person. In addition, he acknowledged he lacked any observations the wrong dressings or treatments were provided to residents. He confirmed the facility experienced no recent order supply concerns. LPN-B stated, on 7/29/22, he initially applied the VAC to R7 and then on 7/30/22 he reapplied it as R7 messed with it. He confirmed these were the only two days R7 utilized the VAC per his knowledge. He indicated staff found the VAC that morning (8/9/22) after it was reported missing. LPN-B explained R7's family was indecisive with the initial VAC order and once R7's husband agreed to the treatment, they ordered the VAC. When questioned why R7's MAR/TAR lacked the VAC order, after his review of her orders, he expressed he was unsure and confirmed the order was not processed. In addition, he acknowledged the VAC order was expected to be in her MAR/TAR, along with any documentation related to the VAC placement, R7's reaction to the VAC, and reason for its discontinuation. LPN-B stated R7 was not a resident who tampered with her dressings and her husband was often her to help keep an eye on her so she did not. He identified R7 was to be turned and repositioned every two hours and he commented, Most of the time she is out and about with her husband and in the wheelchair. He acknowledged, after review of the WCP recommendations for repositioning, that R7 should have an order for the hourly repositioning. He verbalized increased repositioning for R7 may have assisted in promoting healing and there was a risk of delayed healing for R7 as she was not repositioned per the WCP recommendations.<br><br>During interview on 8/9/22, at 1:39 p.m. the DON stated the WCP dictated notes and orders did not come the traditional way as other provider orders were received. She confirmed the WCP dictation and orders were available for review within 24 hours in which nurse management and leadership was responsible to make sure the orders were updated, current, and processed as wrote by the WCP. In addition, she expected staff to follow the order as prescribed and if there were concerns identified with the order, the provider was to be contacted for clarification. The DON stated if staff failed to follow an order as prescribed staff were not doing what they were expected to do, which could cause a wound infection. The DON confirmed there were issues with R7's VAC order being implemented, mainly related to concerns with facility, family, and WCP conversations not aligning. She stated R7's VAC orders should have been processed when it was originally ordered and confirmed she had not yet followed up with LPN-B related to her documentation and order processing concerns related to R7.<br><br>A policy for physician order processing and transcription was requested. An undated policy Medication and Treatment Orders was provided and identified the policy's purpose was for medication and treatment orders to be consistent with principles of safe and effective order writing. The policy identified drug and biological orders were to be recorded on the Physician's Order Sheet in the resident's chart. The policy lacked direction on the facility's process for nurse order processing and transcription or expectations related to medication and/or treatment administration.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An undated policy Wound Care identified the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. The policy directed staff to verify the physician order prior to the treatment and document specific information in the resident's medical record after completion i.e. type of wound care provided, any changes in the resident's condition, all assessment data obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints reported, and if the resident refused the treatment and the reason why. In addition, the policy directed to notify the supervisor if the resident refused the wound care and to report other information in accordance with facility policy and professional standards of practice.<br><br>43083 |

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| | 245289 | A. Building<br>B. Wing | 08/09/2022 |

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| The Terrace at Crystal LLC | 3245 Vera Cruz Avenue North<br>Crystal, MN 55422 |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083<br><br>Based on observation, interview and document review, the facility failed to assess and re-assess to develop and implement a person centered dementia care treatment plan and failed to follow outside professional help's recommendations for 1 of 1 resident (R1) reviewed who had behaviors related to dementia.<br><br>Findings include:<br><br>R1's annual minimal data set (MDS) dated [DATE], indicated R1 had a diagnosis of dementia and had severely impaired cognition. Further review of MDS, indicated R1 did not exhibit physical behaviors.<br><br>R1's care plan dated 12/11/19, indicated R1 was physically aggressive (hitting other residents) related to diagnoses of dementia and depression. Further R1's care plan directed staff to administer medications as ordered, assess and anticipate needs, modify environment (reduce noise, place familiar objects in room), and when R1 become agitated intervene before agitation escalates, guide aware from source of distress, engage calmly in conversation, if response from R1 continues to be aggressive staff are to walk away calmly and approach later. R1's care plan lacked evidence R1 had been re-assessed following increased physical behaviors to develop appropriate interventions following recent incidents of R1 physically abusing other residents, or threatening behaviors directed towards other residents to safeguard vulnerable residents living with/near or vicinity of R1, and R1's rejection of care from staff.<br><br>R1's Associated Clinic of Psychology (ACP) visit note dated 7/6/22, indicated R1's referral to ACP services was related to sporadic behavior outbursts and non-compliance. Further, ACP note recommended for R1 to have ACP psychiatric practitioner complete a medication review due to previous reports of behaviors in the recent past and constant sleeping throughout the day.<br><br>On 8/1/22, at 3:00 p.m. R1 was observed in her room with a magazine and asking for surveyor's assistance to read the magazine.<br><br>On 8/3/22, at 11:20 a.m. R1 was observed sitting in her wheelchair in the dining room alone and had two coffee cups in front of her.<br><br>-At 12:53 p.m. TMA-B was observed to assist R1 into the day room, turned on music at a loud level, and walked away from R1 without offering another activity.<br><br>-during continuous observation starting at 1:27 p.m. surveyor heard screaming coming from the day room (open common area that include nursing station/hallway threshold /day room). Surveyor observed R1 continuing to yell out in the day room while additional staff removed the resident R1 aggressed towards from the day room. R1 remained in the day room with other residents, with no attempt from staff to redirect R1 to other positive activities.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -At 1:46 p.m. TMA-B was observed to be at the medication cart at the nursing station and R1 was observed to be upset and making punching actions towards another male resident in the day room. R1 then self-propelled to the resident and kicked him in the leg. TM-B responded and separated the residents and staff removed the male resident from the area. R1 again remained in the day room with other residents, and no facility staff in the proximity or an offer of other positive activities to focus on. R1 was observed to yell, point, and stick her tongue out at a female resident who was sitting in a stationary chair by the nurse's station. TMA-B returned to the medication cart at the nurse's station. At 1:56 p.m. TMA-B and health unit coordinator (HUC)-B were observed at the nursing station on their computers, while R1 was observed again making faces and sticking out her tongue at the female resident sitting in the chair, neither staff intervened or redirected R1 at that time. R1 began to self-propel in wheelchair towards the female resident and got to the medication cart when TMA-B intervened and redirected R1 with conversation while again removing the other resident from the area.<br><br>On 8/3/22, at 2:12 p.m. NA-E indicated residents who exhibit behaviors each care plan would direct staff with interventions on what to do when a resident was exhibiting behaviors. In addition, NA-E stated they did not know about R1's behaviors and was not aware of R1 being physically aggressive towards other residents.<br><br>On 8/2/22, at 10:26 a.m. nursing assistant (NA)-A stated R1 would refuse care and was known to be physically aggressive a lot. Further, NA-A stated R1 was hard of hearing and would often get upset with staff and residents if they were unable to understand what R1 was saying. NA-A stated interventions were to reapproach and while in the commons area with other residents' staff were expected to watch and to sit in the room while R1 was in the commons area.<br><br>On 8/2/22, at 11:36 a.m. NA-B indicated R1 had confusion and behaviors which consisted of being resistive to cares and physically aggressive towards staff and other residents. NA-B was unaware of interventions for R1's behaviors related to her dementia.<br><br>On 8/2/22, at 12:02 p.m. trained medication assistant (TMA)-A stated R1 had an explosive temper and you can't come close to her, or she will hurt you. TMA stated staff were directed to keep other residents away from R1 and watch R1 at a distance. Further, TMA-A indicated R1 was resistive to cares and taking scheduled medications and staff were directed to reapproach R1 later.<br><br>On 8/2/22, at 12:26 p.m. registered nurse (RN)-A indicated R1 was resistive to cares from staff and would become physically aggressive with staff and residents. Further, RN-A stated staff were expected to reapproach R1 when less agitated, offer for her to lay in bed to rest, or offer books to read.<br><br>On 8/2/22, at 4:01 p.m. licensed practical nurse (LPN)-A stated R1 would get agitated and fight with roommate and at times R1 was difficult to redirect and calm down. LPN-A was unaware of interventions in place for R1's behaviors related to her dementia.<br><br>(continued on next page) |

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| F 0744<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/2/22, at 4:53 p.m. social services (SS) stated R1 had physical behaviors and can't be near most residents. SS stated staff were expected to separate R1 from other residents by 3-4 feet when agitated to give her some space. Further, SS confirmed R1 had not been re-assessed following increased behaviors of physical agression to determine appropriate interventions and R1's care plan had not been updated since December of 2019. SS stated the nursing department would be the ones to update a resident's behavior and dementia care plans. When asked how a resident's behaviors are monitored, SS-A stated the licensed nurses will document in a progress notes any behaviors and reassess the resident for appropriate behavioral interventions, but SS-A was unsure how staff were monitoring if the behavior interventions were effective. In addition, SS-A indicated R1 was referred to be seen by ACP providers for her behaviors. SS-A stated following each visit with ACP the provider will write a note and SS-A would review the visit note for recommendations which then SS-A would either get new orders or update the care plan if needed. SS-A reviewed R1's ACP visit note dated 7/6/22, and confirmed she did not see the recommendation listed. SS-A stated a medication review by the ACP psychiatric practitioner would have been beneficial for R1 as they could have made medication changes to aid R1 with sleeping better at night and prevent R1 from exhibiting behaviors. In addition, SS-A stated she was not sure if staff were trained related to dementia care and behaviors and felt the staff who work the memory care unit need more education.<br><br>On 8/3/22, at 10:04 a.m. NA-D indicated R1 had exhibited physically aggressive behaviors and was resistive to care but staff on the memory care unit don't understand the resident's and don't listen for example staff would put on a random movie and not one that the residents would like or put on music then R1 would become agitated. In addition, NA-D indicated staff would benefit from additional training related to dementia care and behaviors.<br><br>On 8/3/22 at 4:35 p.m. interview with nurse manager and director of nursing (DON), DON confirmed R1 had not been re-assessed to determine appropriate interventions for increased physical behaviors and R1's care plan had not been updated since 2019, as well as the care guide sheet as of 8/3/22, had no safety interventions for R1's behaviors. In addition, DON stated the interdisciplinary team (IDT) reviews the ACP visit notes at the facility's weekly behavior meetings and implement the recommendations. DON confirmed R1's medical record lacked evidence a medication review was completed as recommended by ACP on 7/6/22.<br><br>Review of facility policy titled Care Plans-Comprehensive, not dated, indicated the resident's comprehensive care plan is developed within seven days of the completion of the resident's MDS. Further, care plan indicated identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require data gathering, proper sequencing or events and complex decision making.<br><br>Review of facility policy titled Behavioral Assessment, Intervention and Monitoring, not dated, indicated the interdisciplinary team (IDT) will thoroughly evaluate new or changing behavioral symptoms to identify underlying causes and address any modifiable factors that may have been contributed to the resident's change in condition. The IDT will evaluate behavioral symptoms in residents to determine the degree, severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and others from harm. Further review of policy indicated the care plan will include targeted and individualized interventions for the behavioral symptoms and how the staff will monitor for effectiveness of the interventions. Interventions will be adjusted based on the impact on behavior. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43080<br><br>Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were acted upon, addressed, and documented in the medical record for 5 of 5 residents (R2, R5, R4, R1, R8) who received recommendations from the pharmacist.<br><br>Findings include:<br><br>R2, R5, R4, R1, and R8's Omnicare of Minnesota Consultation [pharmacy] Reports were requested and provided by the facility after medical record review identified the medical records lacked the pharmacy reports. The medical records and provided printed reports identified the following:<br><br>R2's quarterly Minimum Data Set (MDS), dated [DATE], identified R2 was diagnosed with an anxiety disorder and dementia and received antianxiety medication seven days a week. R2's face sheet, printed 8/9/22, indicated her dementia was with behavioral disturbances.<br><br>R2's Consultation Report, dated 3/4/22, indicated her medication regimen was reviewed by the CP and identified she had two orders for clonazepam (anti-anxiety medication) which when combined appeared she was ordered to take 0.25mg three times a day if the once a day and twice a day orders were combined. The report recommended to clarify and update the medication administration record accordingly. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature.<br><br>R2's medical record was reviewed and showed evidence she was ordered, on 3/3/22, clonazepam 0.25mg twice a day AND 0.25mg once a day for anxiety [combined dosages equaled 0.25mg three times a day]. Her March MAR identified an order, initiated 3/4/22, for clonazepam 0.25mg twice a day and lacked the 3/3/33 ordered 0.25mg once a day dosage. Her order summary, reviewed 8/9/22, continued to direct staff to administer the twice a day dosing only. R2's medical record lacked evidence the CP's recommendation for clarification was forwarded, reviewed, and/or acted upon by the physician and/or staff despite the recommendation being made over five months ago or that the physician, from 3/4/22 through 8/9/22, discontinued the 0.25mg once a day order.<br><br>R5's quarterly MDS, dated [DATE], identified R5 was diagnosed with chronic pain and was not administered opioid medication during the review period.<br><br>R5's Consultation Report, dated 6/1/22, indicated his medication regimen was reviewed by the CP and identified R5 was ordered oxycodone (narcotic pain medication) 5mg PRN that was not administered in over 60 days. The report recommended the PRN oxycodone be discontinued due to non-use. The report continued and provided an area for the physician and DONs responses/signatures. The report lacked a physician's or DONs response and both signatures.<br><br>R5's medical record was reviewed and lacked evidence the CP's recommendations on R5's PRN oxycodone was forwarded, reviewed, and/or acted upon by the physician despite the recommendation being made approximately two months prior and R5's June through August MAR's continued to show an active order for PRN oxycodone with no record it was administered.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R4's significant change MDS, dated [DATE], identified R4 was diagnosed with a thyroid disorder, anxiety and depression.<br><br>R4's Consultation Report, dated 6/1/22, indicated her medication regimen was reviewed by the CP and identified she was ordered lorazepam (anti-anxiety medication) 1mg TID (three times a day) PRN for anxiety. The report recommended if the medication could not be discontinued, current regulation required the prescriber to document the indication of use, the intended duration of therapy (a stop date), and the rationale for the extended time period. The report continued and provided an area for the physician and director of nursing responses/signatures. The report lacked a physician's response and both signatures.<br><br>A subsequent Consultation Report, dated 7/6/22, identified R4 received a thyroid replacement medication; however, a recent TSH lab was not located in her medical record. The CP recommended to monitor a TSH level on the next convenient lab day. The report continued and provided an area for a physician response and associated physician and DON signature sections. The report lacked a provider and DON response/signatures.<br><br>R4's medical record was reviewed and lacked evidence the CP's recommendation for lorazepam review and a TSH level were forwarded, reviewed and/or acted upon by the physician despite the recommendations being made over 60 and 30 days respectively and she was ordered and/or received the dosing of the medications which were identified needed review and TSH monitoring.<br><br>R1's annual MDS, dated [DATE], identified R1 was diagnosed with dementia and depression and received antipsychotic medication seven days a week. R1's face sheet, printed 8/9/22, indicated her dementia was with behavioral disturbances.<br><br>R1's Consultation Report, dated 6/2/22, indicated her medication regimen was reviewed by the consulting pharmacist (CP) and was identified she received an antipsychotic medication. The report recommended R1's orthostatic blood pressures (BP) were routinely monitored. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature.<br><br>A subsequent Consultation Report, dated 6/2/22, indicated R1 was ordered quetiapine (antipsychotic medication) 12.5mg (milligrams) every 6 hours PRN (as needed) for anxiety/restlessness which was in place for greater than 14 days without a stop date. The report identified CMS (Centers for Medicare and Medicaid) required PRN orders for antipsychotic medications to be limited to 14 days. A new order was not to be written without the resident being directly examined by the prescriber who personally assessed the resident's condition and progress to determine if the PRN antipsychotic was still needed. The report recommended to discontinue the PRN order or add a 14 day stop date and recommended the addition of a supporting diagnosis. The report continued and provided an area for the physician and director of nursing responses/signatures. The report lacked a physician's response and both signatures.<br><br>R1's medical record was reviewed and lacked evidence orthostatic BPs were initiated per a physician or nursing order or that R1 refused orthostatic BP check attempts. In addition, her medical record lacked evidence the PRN quetiapine recommendation report was forwarded, reviewed and/or acted upon by the physician despite the recommendation being made over 2 months prior and R1's Order Summary Report, printed 8/9/22, indicated a PRN quetiapine order, dated 5/9/22, provided a diagnosis of restlessness/anxiety and lacked a stop date.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R8's admission MDS, dated [DATE], identified R8 was diagnosed with gastroesophageal reflux disease (GERD) and constipation.<br><br>R8's Consultation Report, dated 6/13/22, indicated on admission he was ordered senna-docusate 8.6-50mg 2 tabs twice a day (BID) PRN for constipation; however, the PRN was not listed on the June MAR. The report recommended staff clarified the medication order or added the PRN order to the MAR if the order remained current. The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature.<br><br>A subsequent Consultation Report, dated 7/6/22, identified R8 received ibuprofen (nonsteroidal anti-inflammatory medication) 600mg every day (QD) in which administration with food and adequate fluid could minimize gastrointestinal (GI) distress. The report recommended to ensure the ibuprofen was administered at meal time or with food and adequate fluid (4 to 8 ounces). The report continued and provided an area for the DON to comment and sign. The report lacked a DON response/signature.<br><br>R8's medical record was reviewed and lacked evidence the CP's recommendations on R8's PRN senna-docusate or ibuprofen administration were either addressed by the DON or forwarded, reviewed, and/or acted upon by the physician despite the recommendation being made approximately two and one months respectively prior and R8 continued to receive ibuprofen QD.<br><br>During a telephone interview on 8/9/22, at 10:55 a.m. the CP stated, effective 7/31/22, Omnicare no longer provided consulting pharmacy services to the facility. She explained after she completed her monthly medication reviews, she emailed the reviews to the DON and expected the DON to distribute the reviews/recommendations to the providers or nurse managers. Further, she expected the reviews/recommendations to be addressed with the next routine physician visit or by the review's recommended date. If the facility followed this time frame expectation, the completed reviews and addressed recommendations would then be available for her follow up review with her next visit, which she stated was part of her review process. She explained indication(s) of provider or facility review would be identified on the review with a provider and/or DON response and signature. The CP indicated she participated in the facility's quality assurance (QAPI) committee process. She stated, from 2/1/22 through 4/30/22, the facility's 30 day response/completed rate was 85 percent (%) and their 60 day rate was 89%. She indicated it [rate] was pretty good. She stated she lacked any overall concerns with the facility's process for the reviews; however, she identified there were times when her prior reviews were not yet scanned into the medical record for her review.<br><br>When interviewed on 8/9/22, at 11:49 a.m. nurse manager (LPN)-B stated he occasionally reviewed CP recommendations when they come to my knowledge; however, most of the time the DON followed up with the reviews and he was not too sure if he addressed any of the recommendations since he started his position approximately two months ago. He acknowledged the reviews were sent to him and the DON via email. He explained the importance of timely completed pharmacy recommendations was related to patient safety and correctly administered medications. If the reviews were not addressed timely, a resident could experience adverse effects and the sole purpose of that medication will not be met. He denied knowledge the facility experienced any concerns with the review/recommendation process.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During interview on 8/9/22, at 1:39 p.m. the DON stated after her hire date in April, she started to receive emailed CP reviews in May which she passed them on to where she felt they needed to go (psychiatrist, physician box, etc.) for review and follow-up. She stated some of the reviews were returned and stated further, today (8/9/22), social services informed her the psychiatrist was not addressing the reviews/recommendations and just kept them for their records. She was unsure as to what the other providers were doing with their reviews or where they were going once addressed. The DON acknowledged audits were not performed to ensure the reviews were addressed, returned, and scanned into the residents' medical records and stated she needed to have conversations with the providers to start working on the review process. She reported there was a significant back log of scanning that needed to be completed and explained she was informed, Paperwork is not life and death and thus not really important. She stated the scanning needed to be completed; however, the facility had patients to take care of. The DON stated, If there is not a progress note [in the resident's medical record] that I worked on it, it was not touched [completed]. She verbalized CP reviews/recommendations were important for the betterment of the patient and risk factors related to an incomplete process depends on the recommendation.<br><br>A consulting pharmacist policy was requested. An Omnicare, A CVS Health company policy, 9.0 Pharmacy Consultant Services, revised 4/1/17, was provided and identified the policy lacked directives for the CP and/or for the facility related to the CP recommendation review process. A policy for the current consulting pharmacy medication review services was not provided.<br><br>43083 |

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| F 0835<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>43007<br><br>Based on interview and document review, the facility failed to ensure concerns identified on the previous survey had appropriate oversight by the administrator to ensure the facility corrected deficient practice and use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This deficient practice had the potential to affect all 65 residents at the facility.<br><br>Refer to F607, F684, F686, and F756.<br><br>Findings include:<br><br>Review of current facility policies and procedures, documentation, resident's medical records identified current deficient practice remained.<br><br>Interview on 9/27/22 at 1126 a.m., with the administrator identified he had not overseen work performed by the former director of nursing (DON) to ensure deficient practice was corrected. The administrator stated, No plans of correction have been done .the past DON didn't complete anything .no education .nothing .so we know you will have to recite them all and we are now going to get to work on it all.<br><br>No policy or procedure on administrative oversight was provided by the end of the survey. |