STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview and document review, the facility failed to immediately report incidents of potential resident to resident abuse to the State agency (SA) within two hours, as required, for 2 of 2 residents (R1, R6) who had been involved in resident to resident altercations. Findings include: R1's Progress Note (PN) dated 4/15/20, at 5:16 a.m. indicated R1 had not slept during the shift and had complained his roommate (R5) came up to him with his penis in his hand and put it up to R1's face and said, suck my dick. R1 stated he left the room and could not and would not sleep in the room. R1 requested his room to be changed. R1 slept in the dining room. R1's PN dated 4/15/20 at 7:28 a.m. indicated the director of nursing (DON) and administrator had been updated via voice mail regarding R1's report of potential sexual abuse. The Nursing Home Incident Report (NHIR) submitted to the SA on 4/15/20, at 11:03 a.m. indicated R1 was a new admission to the facility and was alert and oriented and could state his needs. R1 had not slept during the shift. R1 had reported his roommate, R5, came to him with his penis in his hand to his face and said suck my dick. R1 stated he left the room and could not and would not sleep in the room. R1 wanted his room to be changed from this roommate. R1 had been sleeping in the dining room. The report also identified R1 had changed rooms and law enforcement had been notified. On 6/19/20, at 11:24 a.m. the administrator verified the aforementioned details of the incident which occurred between R1 and R5. The administrator confirmed the progress note had been documented at 5:16 a.m. and the allegation had not been reported to the SA until 11:03 a.m. The administrator confirmed the allegation was not reported to the SA timely and should have been reported within two hours, as required for allegations of abuse. On 6/17/20, at 4:15 p.m. R6 indicated he had recently moved into a new room after having been discharged from the facility COVID unit. R6 stated when he was in the COVID unit, his roommate had attacked him and verbally abused him, yelling faggot at him. R6 stated R7 had also hit him, indicating R7 had struck his arms which had been crossed in front of his body. R6 stated the nurse had to come in and take R7 out of the room. R6 stated he thought R7 had been drunk. R6 indicated the incident had occurred a week or two prior and stated he had filed a complaint at the time of the incident as well as notified the Ombudsman for Long-Term Care. R6 stated he felt safer now that he was away from R7 and indicated he was not really afraid of him. R6 stated R7 had verbally abused him several times, but when R7 started hitting him was when R6 had said no. R6 indicated R7 had come into his room on the COVID unit one other time since the incident and he had asked staff to remove him. R6 stated he had not seen R7 since that time. R6 reported he notified the social worker of his complaint and stated he was a little on edge and wondered what would happen if he ran into R7 again. Review of R7's PNs revealed a note dated 5/20/20, at 12:17 a.m. which indicated R7 was very intoxicated with alcohol and belligerent. R7 attempted to punch his roommate (R6) in the face, but R6 put his hand over his face to block the punch resulting in R7 punching R6 on the hand. R6 did not sustain any injury during the incident. The facility's Nursing Home Incident Report (NHIR) dated 5/20/20, indicated submission time was 11:17 a.m., 11 hours after the incident had occurred and not within two hours, as required. On 6/19/2020 at 1:59 p.m. the administrator stated he had been notified of the aforementioned incident and verified he did not report it to the SA agency until 11:17 a.m. The administrator verified he should have reported to the SA within the required two hour timeframe, as required. The undated Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy directed abuse allegations (abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property) were reported per Federal and State law. The policy indicated the facility would ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation or resident property were reported immediately, but not later than two hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the SA and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures.
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of a resident's needs, strengths, goals, history, and preferences for 1 of 4 residents (R4) reviewed for pressure ulcers. Findings include: R4's significant change Minimum Data Set ((MDS) dated [DATE], indicated R4 was in a persistent vegetative state with no discernible consciousness and was totally dependent on staff for all activities of daily living (ADL). The MDS indicated R4 was at risk for developing pressure ulcers and had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough and may also present as an intact or open/ruptured serum-filled blister.) The MDS also indicated R4 required a pressure reducing device for chair and bed, a turning and repositioning program, pressure ulcer care and application of ointments/medications and nonsurgical dressings other than to feet. R4's significant change Care Area Assessment (CAA) summary dated 4/28/20, identified five care areas had triggered from the data entered into the MDS requiring analysis. The following areas were triggered: Urinary Incontinence and Indwelling Catheter, Nutritional Status, Feeding Tube, Dehydration/Fluid Maintenance, and Pressure Ulcer R4's Pressure Ulcer/Injury CAA dated 5/4/20, revealed multiple pre-checked areas which included existing pressure ulcer/injury, extrinsic risk factors, [MEDICATION NAME] risk factors, [DIAGNOSES REDACTED]. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which could have impacted R4's pressure ulcer/injury status. The CAA further lacked any other considerations which could have affected R4's pressure ulcer/injury status from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. On 6/19/20, at 2:25 p.m. registered nurse (RN)-D verified she was the MDS coordinator and confirmed the analysis for R4's pressure ulcer CAA was blank. RN-D indicated she had experienced some technical difficulties with her CAA's, however stated the analysis should have been completed. RN-D indicated the facility followed the RAI manual and did not have a specific facility policy related to the completion of the CAA's. RN-D indicated the facility did not have a specific policy related to CAA's however, utilized the RAI manual. The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.17.1 dated October 2019 indicated

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

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.

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F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected pressure ulcer status for 2 of 4 residents (R1, R4) reviewed for pressure ulcer. Findings include: R1's Significant Change Minimum Data Set ((MDS) dated [DATE], Section M: Skin Conditions question M0300B identified R1 had three stage 2 pressure ulcers, which had been present upon admission/reentry. Question M0300C, M0300D, and M0300E identified R1 had no stage 3, stage 4 or unstageable pressure ulcers. R1's Discharge MDS dated [DATE]., Section M: Skin Conditions question M0300B identified R1 had two stage 2 pressure ulcers, which had been present upon admission/reentry. Question M0300C, M0300D, and M0300E identified R1 had no stage 3, stage 4 or unstageable pressure ulcers. R1's Weekly Wound Assessments dated 5/22/20, revealed R1 had four pressure ulcers/injuries: -Stage 2 pressure ulcer of left buttock, first identified 4/14/20, measured 2 centimeters (cm) x 1 cm x 0.1 cm with 30% granulation, 70% skin, -Stage 2 pressure ulcer of right buttock, first identified 4/14/20, measured 4 cm x 2 cm x 0.1 cm with 40% granulation and 60% skin without drainage. -Stage 2 pressure ulcer of left ankle, first identified 4/14/20, measured 0.8 cm x 1.1 cm x 0.1 cm with 100% scab surrounding area intact. -Stage 2 pressure ulcer of plantar area of left foot, first identified 4/14/20, measured 0.5 cm x 0.5 cm x 0.1 cm with 100% scab. R1's Weekly Wound Assessments dated 5/28/20 revealed R1 had six pressure ulcers/injuries: -Stage 2 pressure ulcer of left buttock, first identified 4/14/20. R4 declined left buttock assessment -Stage 2 pressure ulcer of right buttock, first identified 4/14/20. R4 declined right buttock assessment -Stage 2 pressure ulcer of left ankle, first identified 4/14/20, measured 1.1 cm x 1.1 cm x 0.1 cm with 20% slough and 80% granulation with surrounding area intact. -Stage 2 pressure ulcer of plantar area of left foot, first identified 4/14/20, measured 0.5 cm x 0.5 cm x 0.1 cm with 100% scab. -right lateral elbow identified as pressure, however the stage was not identified, documented as first identified 4/14/20, measured 1.5 cm x 1.5 cm x 0.1 cm identified with 100% scab. -left elbow wound identified as pressure, however, the stage was not identified, documented as first identified 4/14/20. The wound measured 5 cm x 0.7 cm x 0.1 cm with 80% skin and 20% necrotic with surrounding area intact. R1's Weekly Wound Assessments dated 6/5/20, revealed R1 had six pressure ulcers/injuries: -Stage 2 pressure ulcer of left buttock, first identified 4/14/20. R4 declined left buttock assessment -Stage 2 pressure ulcer of right buttock, first identified 4/14/20. R4 declined right buttock assessment -Stage 2 pressure ulcer of left ankle, first identified 4/14/20, measured 1 cm x 0.9 cm x 0.1 cm with 10% slough and 60% granulation and 30% dermis with surrounding area intact without drainage. -Stage 2 pressure ulcer of plantar area of left foot, first identified 4/14/20, measured 0.5 cm x 0.4 cm x 0.1 cm with 100% scab. -right lateral elbow, identified as pressure, however the stage was not identified, documented as first identified 4/14/20, measured 1.2 cm x 1.1 cm x 0.1 cm identified with 100% scab with surrounding area intact. -left elbow wound identified as pressure, however, the stage was not identified, documented as first identified 4/14/20. The wound measured 5 cm x 0.7 cm x 0.1 cm with 80% skin and 20% necrotic with surrounding area intact. On 6/18/20, at 10:04 a.m. registered nurse (RN)-B indicated she was the wound nurse for the facility and verified R1 had ankle, foot and left buttock wounds upon admission to the facility and subsequently developed a pressure ulcer on his right buttock and left elbow. RN-B stated R1 had a bruise to the right elbow upon admission and thought it had maybe developed into a scab. Shortly there-after, RN-B indicated she made weekly rounds with the wound doctor, of the facility residents with wounds. RN-B stated she waited for the physician to complete documentation and once that was completed, she had a week to complete her documentation of the wounds reviewed. R4's Significant Change MDS dated [DATE], Section M: Skin Conditions question M0300B identified R4 had one stage 2 pressure ulcers, which had not been present upon admission/reentry. Question M0300C, M0300D, and M0300E identified R1 had no stage 3, stage 4 or unstageable pressure ulcers. R4's Weekly Wound Assessments dated 4/22/20, revealed R4 had two pressure ulcers/injuries. -left elbow wound identified as pressure, however, the stage was not identified, documented as first identified 3/17/20. The wound measured 3 cm x 3 cm x 0.1 cm with 40% necrotic, 15% slough, 45% granulations. Left elbow had scant serous drainage noted. -left buttock wound identified as pressure, however the stage was not identified. The wound measured 2 cm x 1.5 cm with 50% granulation and 50% dermis with scant drainage on 4/22/20. On 6/19/20, at 2:25 p.m. RN-D verified she was the facility MDS coordinator and was responsible to complete Section M of the RAI (Resident Assessment Instrument) . RN-D indicated she reviewed the resident wound documentation for completion of the section. R1's clinical record was reviewed with RN-D who verified, according to the documentation R1 would have had four stage 2 ulcers at the time of the 5/31/20, assessment and 6 ulcers at the time of the 6/9/20 discharge assessment. RN-D confirmed the aforementioned MDS assessments were inaccurate. RN-D indicated the facility did not have a specific policy related to CAA's rather, utilized the RAI manual directives. On 6/19/20 at 2:46 p.m. the director of operations (DO) and RN-D explained RN-B did not complete wound documentation at the time of the wound physician visit and indicated there was often a delay in the documentation being available. DO indicated if the delay occurred at the time of the MDS assessment, this would impact the accuracy of RN-D's completion of the MDS. DO indicated this was an issue and confirmed the MDS should be an accurate representation of the resident condition. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2019, identified Section M: Skin Conditions to be completed with an intent to document the risk, presence, appearance, and change of pressure ulcers/injuries. Further, the manual provided several coding instructions, including completing questions M0300B, M0300C, M0300D, and M0300E, directing staff to, Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. Examine the resident and determine whether any ulcers, injuries, scars or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g. sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g. elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).
F 0678 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide basic life support, including cardiopulmonary resuscitation (CPR) in accordance with resident wishes and physician orders [REDACTED]. This deficient practice resulted in an immediate jeopardy (IJ) situation when R4 was found with absent pulse and respirations, and timely CPR was not initiated, and R4 died . In addition, the facility lacked a clear process/procedure for identification and communication of resident code status. This had the potential of affect all 58 residents residing in the facility. The immediate jeopardy began on [DATE], at 3:56 p.m. when R4 was noted to have no respirations or pulse and CPR was not initiated. The administrator, director of nursing (DON), assistant director of nursing (ADON) and unit manager licensed practical nurse (LPN)-C were notified of the immediate jeopardy at 3:21 p.m. on [DATE]. The immediate jeopardy was removed on [DATE], at 4:00 p.m. however, noncompliance remained at a G - isolated scope and severity level, which indicated actual harm that is not immediate jeopardy. Findings include: R4's Admission Record printed [DATE], indicated R4 had [DIAGNOSES REDACTED]. breathing). The record also identified R4's advance directive indicated R4 chose to be full code (full cardiopulmonary resuscitation to be initiated in the event of a medical emergency). R4's Provider Orders for Life-Sustaining Treatment (POLST) dated [DATE], indicated if R4 had no pulse and was not breathing, staff were directed to attempt resuscitation/CPR including the provision of full life sustaining treatment including: intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. The POLST was signed by R4's wife and a facility representative, however, the physician signature section was blank. R4's significant change Minimum Data Set ((MDS) dated [DATE], indicated R4 was in a persistent vegetative state with no discernible consciousness and was totally dependent on staff for all activities of daily living (ADL). R4's care plan dated [DATE], indicated R4 wished to be a full code and directed the staff to review and update R4's code status, annually. The care plan indicated R4's and family request related to resuscitation status, would be honored. R4's Treatment Administration Record dated [DATE], - [DATE], which contained physician medication and treatment orders identified R4 as a

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F 0678 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) full code status in the Advance Directive section of the record. On [DATE], at 9:38 a.m. nursing assistant (NA)-E and NA-F were observed to provide morning cares for R4. Review of R4's medical record for the date of [DATE], revealed the following: -R4's TAR identified the 2:00 p.m. dose of [MEDICATION NAME] 1% ophthalmic solution was administered. The TAR did not identify the actual time administered. -4:42 p.m. Progress Note by registered nurse (RN)-A indicated the nurse checked R4 at 3:56 p.m. and noticed R4 was unresponsive. Nurse called for help and did assessments of R4. R4 had no temperature, no pulse, no respirations or oxygen saturation noted with all tubings in place. Family and health care provider were notified. R4 confirmed expired. -4:53 p.m. Progress Note by LPN-A indicated nurse practitioner contacted regarding resident passing. Awaiting an order to release the body. --5:44 p.m. Progress Note by RN-B, the assistant director of nursing, indicated she was called by two nurses and notified R4 was unresponsive. Upon arrival, R4 was cool to touch, no temperature, no pulse, no respirations or oxygen saturation noted when assessed. Family and health care provider notified per protocol. R4's clinical record lacked documentation as to when R4 was last checked on or provided care by the nursing staff and also lacked documented evidence that CPR had been initiated per R4's identified wishes. On [DATE], at 9:26 a.m. RN-B stated RN-A had been in charge of R4 when he was found unresponsive. RN-B stated the evening nurse had come to the desk and told her R4 had passed away and that two other nurses had been in his room prior to her entering the room. RN-B stated when she got to R4's room, R4 was cold to touch, with no pulse, no respirations, no oxygen saturation, nothing. RN-B expressed surprise as no one had said anything about something going on (with R4). RN-B stated she did not think CPR had been started for R4 per the directive. On [DATE], at 9:29 a.m. the DON stated his investigation into the incident revealed the nursing assistants (NA's) from the evening shift had been doing rounds and RN-A had been at the nurse's station, charting. When the NA's went into R4's room, he was found unresponsive. The NA's went into the hallway and gestured for RN-A to come to R4's room. The DON stated they were not sure how long R4 had been unresponsive, but RN-A's note stated R4 had been cold and stiff. RN-A called in another nurse, LPN-A who then called in RN-B. The DON stated all of the witness statements were the same. The DON indicated the NA staff should have called for help in a more urgent/emergency manner and stated RN-A should have initiated CPR after determining R4 had no pulse or respirations per R4's and family directive. The DON indicated he was currently in the process of educating staff on the CPR policy and calling for assistance during a medical emergency. The administrator stated he had filed a vulnerable adult (VA) report the previous day regarding R4's death. On [DATE], at 12:39 p.m. the DON provided a print out of each Resident Profile with their identified code status and stated he had identified several residents did not have code status orders entered into the computer. The DON verified all residents should have an identified code status readily accessible in their electronic record. Review of the Resident Profile documents identified twenty-eight residents with a status of full code, eleven residents with a code status of DNR (do not resuscitate) and nineteen residents' code status were blank. On [DATE], at 12:52 p.m. RN-A stated if a resident was found unresponsive and was a full code, CPR should be started. RN-A stated he had not received any training on where to look for a resident's code status directive, but knew each resident's paper clinical record contained a POLST and in the event of an emergency, he would look at that for the resident's code status directive. RN-A stated by the time had had been notified by the NA and got into R4's room, R4 was cold and had no pulse. RN-A stated LPN-A and RN-B were brought into R4's room, who also assessed R4 and they all concluded R4 had died because he was cold and his arms were stiff. RN-A confirmed R4 was a full code status, but stated he was not aware of any specific criteria to which would indicate not to begin CPR rather, he just used nursing judgement. RN-A verified he had not started CPR for R4 as he was cold and stated to his knowledge, there was no point of doing CPR. On [DATE], at 1:04 p.m. NA-A stated would she would call for the nurse if she found a resident unresponsive and the nurse would direct actions to be taken. On [DATE], at 1:07 p.m. LPN-B stated in the event of a medical emergency, she would look on the computer for the resident code status and if it was blank, she would automatically set up a code blue which included putting the resident on the floor and starting CPR. On [DATE], at 1:42 p.m. RN-C stated each resident's code status was listed on the computer which was where he would look in the event of a medical emergency. RN-C stated if no code status was listed, he would start CPR. On [DATE] at 1:18 p.m. RN-B stated in the event a resident was found unresponsive, the nurse was supposed to assess the resident, and if a full code, start chest compressions, start CPR. RN-B stated the code status information was in the computer and if no code status was noted, the nurse would have to look in the resident's paper chart. RN-B explained if the code status did not display on the electronic record banner, it may have been entered into into the computer wrong which would require the nurse to view another screen which would identify the CPR status, otherwise it would not be viewable. RN-B stated in her opinion, during an emergency, the nurse should not have to scroll around the computer in order to find the information and that some of the nurses may not now how to do that or that the extra step was required. On [DATE], at 2:25 p.m. the DON stated according to facility policy, CPR should have been initiated for R4 when he was found unresponsive. The DON stated although RN-A had completed an assessment and determined R4's arms were stiff, RN-A should have started CPR rather than having additional nurses' complete additional assessments. The undated Emergency Procedure - Cardiopulmonary Resuscitation directed if an individual (resident, visitor, or staff member) was found unresponsive and not breathing normally, a licensed staff member who was certified in CPR/BLS (basic life support) would initiate CPR unless: a. It is known that a Do Not Resuscitate (DNR) order that specifically prohibits CPR and/or external defibrillation exists for that individual; or b. There are obvious signs of irreversible death (e.g. rigor mortis) (biochemical changes in the body produce stiffening of the joints and muscles of the body that usually appears within 2 to 6 hours after death. Rigor mortis begins in the muscles of the jaw and neck and proceeds downwards in the body to the trunk and extremities and complete within 6 to 12 hours) The immediate jeopardy that began on [DATE], was removed on [DATE], when the facility audited all resident records to ensure all residents had an identified advance directive status, obtained physician orders [REDACTED]. The facility also reviewed and revised the Emergency Procedure-Cardiopulmonary Resuscitation policy and educated licensed staff on the policy and where to access resident advance directive information. Additionally, the facility identified a staff education plan which included monthly code drills to ensure CPR would be initiated and developed an audit tool to monitor compliance with individual advance directive status' and staff ability to demonstrate understanding of the advance directive policy and location of the information.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based observation, interview and document review, the facility failed to comprehensively assess and notify the physician regarding the development of a newly formed pressure ulcer, obtain treatment of [REDACTED]. This resulted in actual harm when R4 developed an unstageable pressure ulcer to his right heel which required surgical excisional debridement. Findings include: R4's Admission Record dated 6/19/20, indicated R4 had [DIAGNOSES REDACTED]. breathing) and muscle weakness. R4's significant change Minimum Data Set ((MDS) dated [DATE], indicated R4 was in a persistent vegetative state with no discernible consciousness and was totally dependent on staff for all activities of daily living (ADL). The MDS indicated R4 was at risk for developing pressure ulcers and had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.) The MDS also indicated R4 required a pressure reducing device for chair and bed, a turning and repositioning program, pressure ulcer care and application of ointments/medications and nonsurgical dressings other than to feet. The MDS further indicated the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. R4's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 5/4/20, indicated the significant change assessment was done as R4 had a new stage 2 ulcer, most likely a Kennedy terminal ulcer (dark sore that develops rapidly during the final stages of a person's life) related to his situation. R4's Care Plan dated 3/18/20, indicated R4 was at high risk for impaired skin integrity and identified R4 had a wound to the left elbow and a stage 2 pressure ulcer to the left buttock related to immobility, incontinence, malnutrition/failure to thrive, reliance on staff for performance of ADL's and type 2 diabetes. The care plan directed R4 required PRAFO (pressure relief ankle foot orthosis) boots on at all times, turn and reposition every two hours while in bed, pressure reducing air mattress in bed and cushion in wheelchair when out of bed, check for bowel and bladder incontinence and provide care every two hours and as needed. The care plan also directed staff to assess/record/monitor wound healing, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the physician, monitor/document/report to physician as needed changes in skin status: appearance, color, signs and symptoms of infection, as well as any new wound size and stage. R4's Braden Scale (a tool which predicts the risk for developing a facility acquired pressure ulcer/injury) dated 3/18/20, identified R4 was very high risk. R4's Braden Scale dated 5/21/20, also identified R4 was very high risk. R4's Weekly Skin Check dated 5/21/20, completed by licensed practical

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) nurse (LPN)-C identified R4 had stage 2 pressure ulcers to the left elbow and left buttock and required daily dressing changes, heel protective boot, and repositioning every two hours. The skin check did not identify any open areas to R4's right heel. On 6/17/20, at 10:17 AM registered nurse (RN)-A was observed to perform dressing changes to R4's wounds. RN-A began with changing the dressing to R4's bottom. RN-A stated R4 had two open areas: the first open area was noted at the top of the buttocks crease and was approximately 0.5 centimeters (cm) x 1.0 cm. The second open area was noted to be approximately 6.0 cm directly below the first and was approximately the size of a pencil eraser. RN-A indicated the wounds were measured on Mondays when seen by the wound nurse. RN-A proceeded to perform a dressing change to R4's left elbow. The old dressing was noted to have a small amount of serosanguinous drainage (mixture of blood and serum). The left elbow wound was noted to be approximately 3.0 x 4.0 cm with slough (a layer of dead tissue separated from surround living tissue) on a majority of the wound bed. RN-A proceeded to remove an old dressing from R4's right foot/heel. The dressing was noted to have a moderate amount of serous drainage. A large wound which consisted of approximately 10.0 cm of eschar (dry, black, hard dead tissue) was observed to cover R4's entire right heel with 1.0-2.0 cm of bloody tissue along the plantar side of the wound. A demarcation of new skin extended approximately 3.0-4.0 cm along the plantar surface of R4's right foot. After completing the dressing change, RN-A applied a pressure relieving boot to R4's right foot. R4's Treatment Administration Record (TAR) dated 6/1/20 - 6/30/20, revealed the following physician medication and treatment orders and nursing orders: -Clean Left buttock with wound cleanser, apply [MEDICATION NAME] (sic) and cover with (border gauze) daily per order. one time a day for wound care -Clean left elbow with wound cleanser apply santyl (a topical product used to help the healing [MEDICAL CONDITION] skin ulcers), [MEDICATION NAME] (sic) and cover with (border gauze) every two days per wound doctor. -Stage II or III wound with drainage: cleanse with water, apply foam composite dressing (facility stock). Change every 3 days and as needed. The order start date was 4/23/20. However, R4's TAR and clinical record lacked identification of and specific orders related to the care and treatment of [REDACTED]. On 6/18/20, at 10:25 a.m. RN-B verified she made weekly rounds with the wound doctor and indicated they had seen R4 on 6/15/20 and discovered he had a right heel wound. RN-B indicated they had been unaware of R4's heel wound prior to that date. RN-B stated when R4 was on the COVID unit, it had been reported to her that R4 had a dry skin area on the right heel and the heel was soft. At that time, she had directed LPN-C to implement foam boots. RN-B stated during wound rounds on 6/15, she was embarrassed when they spotted gauze on the R4's right foot, as the right heel wound had not been reported to her or the wound doctor nor had it been reported or discussed in the facility morning meeting. RN-B stated all she had been aware of was that R4's foot/heel was soft. RN-B verified R4's clinical record lacked documentation regarding the necrotic heel wound and stated she waited for the physician to complete documentation and then she (RN-B) had a week to complete her documentation. RN-B stated the wound doctor debrided R4's wound on 6/15/20, which would explain the wound bleeding. RN-B confirmed R4's right heel wound was an unstageable ulcer and indicated if it had been reported earlier, it may not have gotten so bad. R4's Specialty Physician Wound Evaluation & Management Summary dated 6/15/20, indicated R4 had a new DTI (deep tissue injury) of the right heel and underwent a surgical excisional debridement procedure to remove thick adherent eschar and devitalized tissue. The summary identified an unstageable wound (due to necrosis) of the right heel with a duration of greater than one day and included the following treatment plan. However, R4's clinical record lacked entry of these orders: -Primary dressing: Xeroform sterile gauze apply once daily for 30 days. -Secondary dressing: gauze roll non sterile (kerlix) apply once daily for 30 days; ABD pad sterile apply once for 30 days -Peri wound treatment: skin prep apply once daily for 30 days -Recommendations: float heels in bed; offload wound; reposition per facility protocol; Sponge boot: prevalon boots and wedges Review of R4's Weekly Wound Assessments dated 6/18/20, revealed the assessments were performed on 6/15/20, and not documented in R4's clinical record until 3 days post assessment. The assessments included the following: -stage 2 left buttock cluster wound first identified 3/17/20. The left buttock cluster wound measured 7.0 cm x 1.0 cm x 0.1 cm with 30% granulation and 70% dermis with scant drainage. -left elbow stage 2 pressure ulcer first identified 3/17/20. The left elbow measured 3.0 cm x 2.5 cm x 0.2 cm with 10% necrotic, 10% slough, 40% granulation, 40% dermis with moderate serous drainage. -right heel pressure ulcer, unstageable due to necrosis, which was acquired 6/15/20. During assessment, the right heel ulcer measured 11.0 cm x 11.0 cm with 40% granulation, 10% slough and 50% necrotic with moderate serous drainage. Ulcer was debrided by wound doctor. On 6/18/20, at 5:49 p.m. LPN-C stated about two weeks ago, when R4 was on the COVID unit, he remembered talking to RN-B about R4 having dry skin on his right heel. LPN-C denied R4's heel ulcer being open at that time and stated the skin was more soft from laying in bed. LPN-C verified RN-B had recommended R4 wear a boot to that foot. LPN-C stated R4 had been discharged from the COVID unit on 6/1/20, and estimated the boot was implemented shortly before then. LPN-C denied any staff reporting a concern to him regarding R4's worsening heel ulcer and stated they should have done so. LPN-C indicated the nursing assistants (NA) should be checking residents' skin condition daily with cares and verified the ulcer should have been identified earlier, during the weekly skin check. On 6/18/20, at 5:56 p.m. NA-G verified R4 wore boots on his feet and had a sore on his right heel. NA-G stated R4's right foot was bandaged and she could not say how long R4 had had the bandage on the foot. On 6/18/20, at 6:00 p.m. LPN-E indicated she primarily worked the evening shift and would only deal with resident dressing changes if they were not completed on the day shift. LPN-E stated she did not recall R4 having a wound on his heel. On 6/18/20, at 6:02 p.m. NA-H verified R4 had a bandage on his right foot but could not identify how long it had been there. NA-H indicated she had never assisted with a dressing change for R4 and had never seen his wound. NA-H stated if they noticed any problems with resident skin they were to report to the nurse and document in the computer. On 6/18/20, at 6:17 p.m. the skin observation documentation on the Documentation Survey Reports was reviewed with RN-B. RN-B stated if an NA identified a new open or reddened skin area, she would have expected it be reported to the nurse who should then document a progress note regarding the area. RN-B confirmed R4's clinical record lacked documentation regarding the aforementioned new opened or reddened areas identified. RN-B also verified the NA's were to document their skin observation task in the computer every shift and confirmed the documentation had not been completed daily on each shift, as required. On 6/18/20, at 6:33 p.m. the director of nursing (DON) verified NA staff were to document skin observations every shift, daily and newly identified issues with resident skin were to be reported to the nurse who should then document a progress note and request a wound consultation. DON confirmed R4's necrotic heel wound should have been reported, a wound consult should have been requested when the wound was first identified, and an assessment of the wound should have been completed. During review of R4's skin observation documentation on the Documentation Survey Reports, the DON stated he recognized they had a system issue with reporting of resident skin concerns. The undated Prevention of Pressure Ulcers policy indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and family and addressed. The policy directed to routinely asses and document the condition of the resident's skin for any signs and symptoms of irritation or breakdown. The policy also directed to report any signs of a developing pressure ulcer to the physician.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene was performed for 1 of 1 resident (R4) observed during personal cares and for 2 of 2 residents (R4, R3) observed during a dressing change for pressure ulcer care. Findings include: On 6/17/20, at 9:38 a.m. nursing assistant (NA)-E and NA-F were observed to enter R4's, wash their hands and donne gloves. NA-E opened a large plastic bag and placed it on the floor at the foot of R4's bed while NA-F raised R4's bed to a working height. NA-F proceeded to remove a neck pillow from behind R4's neck and a soiled 4 x 4 gauze from around R4's [MEDICAL CONDITION], and disconnected the strap securing the oxygen tubing to the [MEDICAL CONDITION]. NA-E obtained a basin of water and placed it at R4's bedside. NA-F proceeded to wash and dry R4's face, removed R4's gown and a wedge-shaped pillow from behind R4's back. NA-F washed R4's right side chest, arms and armpits while NA-E washed R4's left side. A dressing was noted on R4's left elbow with a handwritten date of 6/15. NA-F removed her gloves and without washing her hands, donned two sets of clean gloves and uncovered R4's lower body and feet. Both NA's rolled R4 to his right side and NA-E washed and dried R4's back. R4 was returned to his back and NA-E applied a sweater over R4's head and guided his arms through the sleeves. NA-E removed her gloves and without washing her hands, applied clean gloves and proceeded to remove the boots from R4's feet. A gauze dressing was noted on R4's right foot. NA-F opened R4's brief and washed his groin. Both NA's rolled R4 onto his right side, NA-E removed the brief which was soiled with a moderate amount of urine and a smear of stool, and washed R4's bottom which was soiled with stool. A dressing was observed over R4's coccyx area. Without removing the gloves or performing hand hygiene, both NA's applied a clean incontinent brief to R4. NA-E removed her gloves and donned clean gloves without completing hand hygiene. R4 was returned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VICTORY HEALTH & REHABILITATION CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) to his back. NA-F proceeded to remove one set of gloves, apply pants around R4's legs. NA-E opened a gauze pack and placed the gauze under R4's [MEDICAL CONDITION]. NA-F removed her second set of gloves, and without performing hand hygiene, opened the door and exited the room. NA-E dispensed barrier cream to her gloved hand and applied to R4's groin, removed her gloves, discarded the basin of water into the toilet, rinsed and set the basin aside. NA-E washed her hands. NA-F returned to the room and without performing hand hygiene, donned clean gloves, removed the sheet covering R4, and discarded it into the bag on the floor. NA-F removed and discarded her gloves, applied hand sanitizer and left the room to obtain a clean sheet. NA-E lowered R4's bed, raised the head and foot of the bed, and indicated the nurse needed to change R4's dressings. NA-F returned to the room with a clean sheet, and without performing hand hygiene, applied gloves and proceeded to cover R4 with the sheet. NA-E raised R4's bed to a working height, lowered the head of the bed and NA-E and NA-F boosted R4 up in the bed. Both NA's returned the bed to a low position with the head and foot of the bed elevated, bagged the soiled linen and garbage, removed their gloves, and washed their hands. On 6/17/20, at 10:05 a.m. during group interview, NA-E and NA-F indicated hand hygiene was supposed to be completed after cares and between residents. They verified they had not completed hand hygiene after completion of R4's perineal cares and when leaving and returning to the room. NA-E and NA-F verified they should have performed hand hygiene with each glove change. On 6/17/20, at 10:17 a.m. registered nurse (RN)-A entered R4's room with wound dressing supplies. RN-A opened two dressing packages, wrote the date on the dressing's outer surface, washed his hands, applied clean gloves, set up the wound treatment supplies on an over the bed table, and opened additional dressing packages. NA-E and NA-F entered the room, wash their hands, and donned gloves to assist with wound care and proceeded to roll R4 onto his left side. RN-A removed R4's coccyx dressing, discarded it in the garbage, and removed and discarded his gloves. RN-A stated R4 had two open areas, the first was at the top of the buttocks crease and was approximately 0.5 centimeters (cm) x 1.0 cm and the second was noted approximately 6.0 cm directly below the first open area and was approximately the size of a pencil eraser. RN-A stated the wounds were measured on Mondays when seen by the wound nurse. Without first performing hand hygiene, RN-A donned clean gloves, cleansed the upper and lower wounds with wound cleanser and a 4 x 4 gauze pads, applied Xeroform (a sterile, non-adhering protective dressing consisting of absorbent, fine-mesh gauze impregnated with a [MEDICATION NAME] blend) over both wounds, and applied a border gauze dressing (absorptive dressing consisting of three layers: a low-adherent layer protects the wound surface, an absorbent gauze layer absorbs exudate, and a non-woven adhesive tape holds the dressing in place and maintains a moist wound environment) over the Xeroform. RN-A removed his gloves and without performing hand hygiene, donned a clean pair. RN-A proceeded to prepared a piece of Xeroform gauze,and placed a clean washcloth under R4's left elbow. RN-A removed the old left elbow dressing which was observed to have a small amount of serosanguinous (mixture of blood and serum) drainage, discarded in the garbage, removed his gloves, and without performing hand hygiene, applied clean gloves. The left elbow wound was noted to be approximately 3.0 x 4.0 cm with slough (a layer of dead tissue separated from surround living tissue) noted on a majority of the wound bed. RN-A cleansed the wound with wound cleanser and a 4 x 4 gauze pad, applied the piece of Xeroform, and covered with a boarder gauze dressing. RN-A removed his gloves and without performing hand hygiene, donned clean gloves, removed the old dressing from R4's right foot/heel which was noted to have a moderate amount of serous drainage on it. A large wound was observed to cover R4's entire right heel which consisted of approximately 10.0 cm of eschar (dry, black, hard dead tissue) and 1-2 cm of bloody tissue along the plantar side of the wound. A demarcation of new skin extended approximately 3-4 cm along the plantar surface of R4's right foot. RN-A removed his gloves and without performing hand hygiene, donned clean gloves, cleansed the wound with wound cleanser and a clean 4 x 4 gauze pad, applied Xeroform over the wound, covered the Xeroform with an ABD bandage (a highly absorbent dressing with a soft outer facing which wicks moisture away) , wrapped the foot with Kerlix (gauze roll), removed and discarded his gloves, applied a pressure relieving boot to R4's right foot, and washed his hands. On 6/17/20, at 11:18 a.m. RN-A verified hands should be washed or hand sanitizer used before and after a procedure. RN-A verified he had not performed hand hygiene after removal of R4's soiled dressings or between wounds and should have done so. On 6/18/20, at 10:25 a.m. the assistant director of nursing (ADON) confirmed hand hygiene should have been completed after removal of a soiled dressing and before application of a clean dressing and between wounds in order to prevent cross contamination from wound to wound. On 6/18/20, at 9:38 a.m. licensed practical nurse (LPN)-C was observed to enter R3's room to do his dressing changes. R3 was observed laying in the bed, with his lower extremities resting on pillows and the head of the bed slightly elevated. R3's heels were floated off the ends of the pillows. LPN-C washed his hands with soap and water, and explained to the R3 what he would be doing. LPN-C proceeded to don clean gloves. R3 lifted his right leg. Without first laying a clean field under R3's foot, LPN-C removed the sock and the old wound dressing which was noted to have minimal reddish, watery drainage on it. R3 set his uncovered heel/foot on top of the previously used pillow. LPN-C removed the gloves, utilized hand sanitizer, gathered wound dressing supplies, donned clean gloves, and cleansed right heel wound with saline spray and a gauze 4 x 4 pad. With the same gloved hands, he picked up the new petroleum gauze and placed it over the wound, followed by a border dressing over the gauze. LPN-C removed his gloves, utilized hand sanitizer, donned clean gloves, put the sock back on R3's right foot, followed by the heel protector. Without first placing a clean field under R3's left root, LPN-C removed the left foot sock and removed the border dressing and Xeroform gauze from the heel of the left foot. The dressing came off clean with no drainage, and once removed, R3 placed his left heel directly on top of the previously used pillow. LPN-C removed his gloves, utilized hand sanitizer, gathered wound care supplies, donned clean gloves, and cleaned the wound with saline spray and a gauze 4 x 4 pad. With the same gloved hands, LPN-C applied the petroleum gauze on the wound and covered it with border dressing. LPN-C obtained a marker from the supplies, wrote the date and his initials on the dressing he had applied, and reapplied the sock and heel protector, removed his gloves, and washed his hands with soap and water. -At 9:55 LPN-C said he did not perform dressing changes very often and was not completely familiar with the procedure for dressing changes. LPN-C indicated he thought he did everything right, but was not sure, however, LPN-C stated he should have washed his hands after cleaning the wound and before starting the other foot's dressing change. In addition, LPN-C stated he should have also ensure a clean field was placed under R3's feet prior to removing the dressings. -At 10:54 a.m. the assistant director of nursing (ADON) stated she was the nurse responsible for wound assessments on R3. The ADON stated she completed wound rounds once a week and indicated R3's wounds were getting better. The ADON stated she would have expected LPN-C to set up a clean area under R3's feet such as a chux (a disposable underpad), and would have expected LPN-C to wash his hands after cleaning the wound and before applying the clean dressing. The ADON confirmed the nurse should have done the dressing change according to facility policy. The undated Handwashing/Hand Hygiene policy indicated all personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The policy directed staff should wash hands with soap and water when visibly soiled, and after contact with a resident with infectious diarrhea. The policy further directed an alcohol-based hand rub or soap and water could be used for the following situations: -before and after direct contact with residents -before performing any non-surgical invasive procedures -before handling clean or soiled dressings, gauze pads, etc -before moving from a contaminated body site to a clean body site during resident care -after contact with a resident's intact skin -after contact with blood or bodily fluids -after handling used dressings, contaminated equipment, etc. -after removing gloves The policy indicated the use of gloves did not replace hand washing/hand hygiene. The undated Dry/Clean Dressings policy directed hand hygiene be performed prior to the procedure, after removal of the soiled dressing, and after the procedure. The policy also directed staff to establish a clean field prior to the procedure.