STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245252	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THIEF RIVER CARE CENTER	2001 EASTWOOD DRIVE THIEF RIVER FALLS, MN 56701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0686 **Level of harm -** 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 on interview and document review, the facility failed to notify the primary physician regarding the development of a newly formed wound and obtain treatment of [REDACTED]. This resulted in actual harm when R1's wound had deteriorated to a necrotic (dead tissue) state, required emergency intervention and hospitalization . In addition, the facility failed to assess, provide and document treatment of [REDACTED]. Findings include: R1's admission Minimum Data Set ((MDS) dated [DATE], indicated he had intact cognition and required extensive assistance from staff for bed mobility, transfers and toileting. The MDS indicated R1 was frequently incontinent of bowel and bladder. R1's MDS identified he was at high risk for pressure ulcer development, however, did not have an active pressure ulcer present. The MDS indicated R1's [DIAGNOSES REDACTED]. R1's care plan dated 4/17/20, identified R1 as cognitively intact and able to express his needs. R1 required assistance with bed mobility, transfers, dressing, grooming, and toileting, was unable to ambulate, was occasionally incontinent of bladder and used incontinence briefs or pads to manage with assistance. The care plan indicated an ulcer was identified on his buttock and directed staff to encourage fluid intake, keep clean and dry, observe skin for signs of redness, blistering, shearing, blanching and skin tears, use pressure reducing cushion in wheelchair and on bed and to reposition every two hours and as needed (prn). On 5/15/20, the care plan identified an open area to R1's left heel, with a goal to be healed within next 90 days. The care plan directed staff to observe weekly and prn, turn and reposition every two hours and prn, treatment as indicated and to float heels when in bed. Buttocks wound A progress note (PN) dated 3/31/20, indicated R1 had an open area on his right gluteal cleft with orders to wash with soap and water, to apply a sacral [MEDICATION NAME] dressing and to change every three days. Review of R1's April and May 2020 treatment record lacked staff direction to care for R1's open area to his right gluteal cleft. Review of R1's PN's for the month of April 2020 lacked documentation related to R1's open area to his right gluteal cleft, that was identified in progress note dated 3/31/20. A nurses's observation note dated 4/6/20, indicated R1's Braden Scale for Predicting Pressure Sore Risk indicated R1 was at risk for skin breakdown. Observations of the area on buttock were described as a cyst like area that was present on admission. R1's medical record lacked documentation of a skin assessment. Heel wound -R1's PN dated 5/9/20, with an entered date of 5/11/20, indicated R1 had a blister that popped on his heel, leaving an open area the size of a silver dollar. Skin prep was applied and the wound was covered with a dressing. -Wound progression noted dated 5/15/20, indicated a new, first recording, of a pressure ulcer to R1's left heel. The note indicated R1 frequently rested pressure on his heel and had been educated to keep the heel elevated and to not rest on it. Documented wound measurements: 2.0 centimeters (cm) x 3.0 cm with eschar (dead or necrotic tissue) present. -PN dated 5/17/20, indicated skin breakdown noted to R1's left heel. Area was cleansed and covered with a dressing. A pillow was placed under his heel to float and keep off the mattress. The note indicated R1 complained his tailbone was sore. The nurse assessed area and applied a dressing to the area per R1's request, however, no open area was identified. -PN dated 5/20/20, indicated R1 complained of pain in his heel and rated it a three on a scale of one to 10 (10 worst pain). -Wound progression note dated 5/22/20, indicated frequently rested pressure on his heel and had been educated to keep it elevated and to not rest on it. R1 was encouraged not to wear shoes. The wound measured 2.0 cm x 2.0 cm and contained slough (dead skin tissue that may have a yellow or white appearance) and [MEDICATION NAME] tissue (tissue regeneration) with slight drainage. -PN dated 5/23/20, indicated R1 complained of pain in his heel and rated it a three on a scale of one to ten. -PN dated 5/25/20, indicated a fax was sent to R1's physician regarding R1's wounds to his coccyx and left heel, 16 days after identification. The physician responded to schedule an appointment with a wound specialist. -PN dated 5/26/20, indicated when R1's dressing was changed on his left heel he complained of pain with light touch along the back of his left lower leg. R1 voiced concerns about his open areas and was asking to see a wound doctor. -PN dated 5/27/20, referred to a call from R1's family member asking if R1 had an appointment to have his heel and coccyx checked. The family member had been informed R1 would be seeing a physician that day. -Wound progression noted dated 5/27/20, indicated the wound bed was dark red in color and moist with a 0.4 cm white circle of skin encircling the wound. The dressing was moderately saturated and exudate (drainage) on the dressing when removed, was almost black and malodorous. A small amount of thick white exudate was removed from the wound bed. -PN dated 5/27/20, referred to a call from the emergency room . The emergency room nurse informed the facility that R1 would be transferring to another hospital for his left heel due to his [DIAGNOSES REDACTED]. progression notes lacked documented evidence of R1 having a buttock wound, monitoring and treatment. Review of R1's medication record for May 2020, revealed there were no treatment orders for R1's wounds on his heel or his buttocks. Review of R1's treatment record for May 2020, directed staff to check R1's blood sugars four times per day, check vital signs daily, draw lab one time per day for [MEDICATION NAME] (blood clotting) time on indicated ordered dates, administer R1's insulin, administer R1's nebulizer treatments, bladder scan when indicated, change nebulizer tubing, and run control for blood sugar machine one day monthly. However, the treatment record lacked any direction or indication to monitor or treat R1's wounds on his heel or his buttock. Review of R1's physicians orders lacked any indication of physician involvement related to R1's wounds, as well as any treatment orders for R1's wounds even though a wound of R1's buttocks was identified on the care plan on 4/17/20, and a wound on R1's heel was identified on 5/9/20. Review of R1's physician office visit progress note, dated 5/27/20, indicated R1 had a necrotic wound on his left heel. R1's wound was documented as a large necrotic area along the medial calcaneus (back of heel) that was malodorous (unpleasant smelling), non-tender to palpation. The wound measured four by five cm. Because of his comorbidities and the need for [MEDICAL TREATMENT], possibly vascular consultation and wound debridement, the emergency room accepted the patient with the goal of transferring him to a higher level of care. Review of R1's emergency room note dated 5/27/20, indicated R1's [DIAGNOSES REDACTED]. R1 was stabilized and transferred to another facility. On 6/4/20 at 9:00 a.m. certified nursing assistant(CNA)-A stated she had seen R1's ulcer on his left heel. She stated she thought it had started out as real small spot and then grew. CNA-A stated when she saw R1's heel it was black in color. On 6/4/20 at 9:15 a.m. registered nurse (RN)-A stated R1 had gotten a blister on his heel. She stated the top layer had peeled off but the area was dry. RN-A stated she looked at it the next week and then over the weekend it fell apart and he was needing to be seen, so they sent him in. She stated R1 went to urgent care after his [MEDICAL TREATMENT] because they felt he could not wait for a wound specialist appointment. RN-A stated the facility had a policy that the physician was to be contacted regarding wounds and decubiti but did not specify who was to contact the physician. RN-A verified R1's primary physician should have been contacted when the wound was first discovered. On 6/4/20 at 9:52 a.m. the director of nursing (DON) stated there had been a break in communication. R1 had a blister and it had not been communicated to everybody, and in fact, she had been unaware of it. DON stated the physician should have been notified with the first assessment of the open area. The DON verified there was no treatment ordered for the care of R1's wound and R1's treatment record lacked any information related to R1's skin care, treatment or interventions. The facility's Skin Ulcer Protocol policy, dated 11-1-15, indicated residents would receive appropriate care and services to prevent, treat, and monitor progress of all healing ulcers. The policy directed staff to report all open skin areas to the facility wound nurse. The staff were to provide wound cares as

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

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F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) indicated by facility wound care guidelines, wound care nurse recommendations and physician orders. The policy further indicated wound care protocol was the physician must be notified of all stage two to stage four wounds, significant changes and non healing wounds. The policy directed staff when considering implementation of the wound care protocols, ensure an appropriate assessment and individualized interventions are in place. Update resident/family and obtain appropriate physician orders. The facility's Significant Change policy, with a revised date 1/7/19, directs staff to immediately inform the resident, consult with the physician and notify the resident's representative, when the resident has a significant change. The policy defined a significant change as a change in a residents status, a need to alter treatment, an accident that results in injury, or a decision to transfer or discharge an individual.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**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 implement appropriate infection control practices related to Covid-19 by failing to conduct required health screenings for all who entered the facility. In addition the facility staff failed to utilized appropriate personal protective equipment (PPE) when providing personal care and treatment to residents as required. These practices had the potential to affect all 67 residents and staff in the facility. Findings include: During observation on 6/2/20, upon entrance to the facility, the state surveyor (SA) was asked to sign in and the SA's temperature was checked. The SA was not asked the required COVID-19 screening questions to assess for symptoms or possible exposure of COVID-19 as required. -On 6/3/20 the SA entered the facility and was asked to sign in and the SA's temperature was checked, however the SA was not asked the required COVID-19 screening questions to assess for symptoms and exposure of COVID-19 as required. -On 6/4/20 the SA entered the facility and was asked to sign in and the SA's temperature was checked, however the SA was not asked the required COVID-19 screening question to assess for symptoms and exposure of COVID-19 as required. On 6/2/20, the director of nursing (DON) confirmed the facility did not have any positive or suspected positive COVID cases in the facility at this time. R2's [DIAGNOSES REDACTED]. R2 had orders for wet to dry dressing change daily but was not on any special precautions. R2 did not exhibit any acute respiratory symptoms and was not COVID positive. On 6/3/20 at 9:00 a.m. Licensed practical nurse (LPN)-A was observed to change R2's wound dressings on her left leg. LPN-A was wearing a surgical mask, gathered supplies and applied gloves. LPN-A proceeded to remove the dressing wrap from around R2's lower leg. LPN-A attempted to remove the 4 by 4 gauze that directly covered the open wounds. The gauze was adhered to the wound and difficult to remove, so LPN-A sprayed the dressing directly with a saline spray. LPN-A then proceeded to remove the 4 by 4 dressing and cleanse the wound. The wounds were moist appearing and had moist drainage present in the wound and on the soiled dressings. LPN-A applied new dressings to the wounds on R2's left leg and secured the dressings with tape. LPN-A discarded the old dressings, removed her gloves and sanitized her hands with alcohol based hand rub. On 6/3/20 at 9:30 a.m. LPN-A verified the treatment observed with R2's dressing change was direct patient care. LPN-A stated she would only wear goggles for treatment if there would be some sort of splashing or something of that nature. On 6/4/20 at 9:35 a.m. RN-A stated staff were required to wash hands, and wear mask and goggles for all patient care. RN-A stated this applied to licensed staff as well as direct care staff. RN-A verified LPN-A should wear goggles while doing treatments. On 6/4/20 at 9:52 a.m. the DON stated she would have to look at the policy but she was sure staff were told to wear goggles for patient care. She stated each worker had their own goggles or face shield that they were responsible to care for. The DON verified LPN-A should have worn goggles to perform dressing changes. The DON further verified visitor screening should have included the COVID-19 screening questions to assess for exposure and symptoms of COVID-19. The facility's Coronavirus Prevention, Screening, and Identification policy, with a revision date of 5/20/20, identified a breach of PPE can result in the spread of infectious pathogens. Breach of PPE can include but is not limited to: inappropriate use of facial mask, poor hand hygiene, improper don/doff of PPE, not using appropriate PPE for the infectious agent and tears or damage to PPE and need to be reported immediately to supervisor. The policy indicated personnel would be assigned to monitor the visitor entrance and evaluate appropriateness of any visitor, utilizing a visitor screening tool. The policy directed staff to do careful screening of visitors for fever or respiratory symptoms and remind visitors to frequently perform hand hygiene.