STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center of Minneapolis	618 East 17th Street Minneapolis, MN 55404

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to report an allegation of abuse to the State Agency (SA) for 1 of 1 resident (R2) reviewed for allegations of abuse. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency on 3/14/24, alleged R2 was physically and emotionally abused by unknown facility staff. The report identified R2 made posts on a social media website including Benedictine is a violence and woman hand head punched cried. R2's Minimum Data Set (MDS) dated [DATE], indicated R2 had diagnoses including aphasia, dementia, and cognitive social or emotional deficit following cerebral infarction (stroke). R2 had severely impaired cognitive skills for daily decision making and physical and verbal behaviors directed at others. R2 sometimes made herself understood and was sometimes able to understand others and required staff assistance with toileting, hygiene, and transferring. The facility's Concern report entry by registered nurse (RN)-A identified a concern dated 3/14/24, and noted RN-A was informed that R2 had been posting on [social media website] phrases such as 'benedictine violence' and 'woman head punch I cry' . Writer spoke with DON and administrator, plan to put a camera in [R2's] room after consent signed to confirm that no abuse is taking place. In an interview on 5/23/24 at 9:15 a.m., the administrator stated he had been made aware that R2 was posting words like hitting on a social media website and had an inter-disciplinary team meeting regarding the concern. The administrator stated the team met and decided we will assume the worst, like maybe somebody is hitting her, maybe she's having rough treatment. The administrator stated if he suspected abuse of a resident had occurred it was his responsibility to immediately report it and start an investigation and the suspicion of abuse had to be reported to the SA within two hours. The administrator noted the statements on the social media website posted by R2 were a problem and if a resident said something that might amount to abuse the facility took it seriously, but he didn't really see R2's writing as cause for suspicion of abuse. In an interview on 5/23/24 at 11:01 a.m., the administrator stated he was going to report the allegations regarding R2 to the SA. (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/23/243 at 2:00 p.m., the director of nursing (DON) stated with R2's post of womanhandheadpunchicried she would be concerned about abuse. The DON stated she did not recall how she became aware of the situation and did not believe it was reported. The DON noted abuse needs to be reported to the SA fairly immediately and there was no specific person who filed reports for the facility. Facility policy titled Abuse Prevention Plan with last revision date 7/21/22, included the community is responsible for reporting suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation in accordance with legal requirements. If the event that caused the suspicion involves abuse or results in serious bodily injury, the individual is required to report the suspicion immediately, but not later than 2 hours after forming the suspicion.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to conduct and maintain records of a thorough investigation into an allegation of abuse for 1 of 1 resident (R2) reviewed for allegations of abuse. Findings include: R2's Minimum Data Set (MDS) dated [DATE], indicated R2 admitted to the facility on [DATE] with diagnoses including aphasia (loss of ability to understand and express speech), dementia, and cognitive social or emotional deficit following cerebral infarction (stroke). R2 had severely impaired cognitive skills for daily decision making and physical and verbal behaviors directed at others. R2 sometimes made herself understood and was sometimes able to understand others and required staff assistance with toileting, hygiene, and transferring. R2's care plan noted R2 was a vulnerable adult and needed assistance to remain safe within the community. The identified goal dated 3/28/24, was any suspected abuse will be investigated in a timely manor [sic] according to facility policy and procedures with an intervention dated 5/12/23 of you will report and investigate any allegations of suspected abuse, neglect, or exploitation. A Vulnerable Adult Maltreatment Report submitted to the State Agency on 3/14/24, alleged R2 was physically and emotionally abused by unknown facility staff. The report identified R2 made posts on a social media website including Benedictine is a violence and woman hand head punched cried. The facility's Concern report entry by registered nurse (RN)-A identified a concern dated 3/14/24, and noted RN-A was informed that R2 had been posting on [social media website] phrases such as 'benedictine violence' and 'woman head punch I cry.' Documentation noted Writer did skin assessment and found no signs of bruising or redness noted to resident's body. Writer spoke with DON and administrator, plan to put a camera in [R2's] room after consent signed to confirm that no abuse is taking place and keep resident safe . Resident remains safe in care given by floor staff, monitoring consent forms signed, camera to be placed in room, staff to be investigated. Findings were identified as A complete exam was done on resident with no findings of any harm or injuries. SS [social services] interviewed fell ow resident on 2nd floor regarding cares provided to all resident on the 2nd floor by all staff including aids and nurses and nothing found supports resident was harmed in any way. The report lacked specific documentation regarding interviews with R2, other residents, or staff. A progress note dated 3/15/24, by RN-A noted writer did skin assessment and found no signs of bruising or redness noted to resident's body. Writer spoke with DON and administrator, plan to put a camera in [R2's] room after consent signed to confirm that no abuse is taking place and keep resident safe . writer called [R2's family member (FM)-A] back, [FM-A] updated on plan . forms placed in [R2's] room for [FM-A] to go over. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/22/24 at 10:07 a.m., FM-A stated they had heard the facility was going to do an internal investigation into the social media posts but wasn't sure what happened with that. FM-A noted they had spoken with the facility about putting cameras in R2's room but decided against it and then things kind of fizzled out, the facility did not reach back out and say what else they would do or what the result of their investigation was. In an interview on 5/22/24 at 11:44 a.m., director of social services (SS)-A stated she remembered hearing something about the social media website posts and I know they [facility staff] did some investigating, I'm trying to remember what it was. I think they determined it wasn't accurate, what she was saying. SS-A noted other staff would know more about the incident. In an interview on 5/23/24 at 9:15 a.m., the administrator stated he had been made aware that R2 was posting words like hitting on a social media website and had an inter-disciplinary team (IDT) meeting regarding the concern. The administrator stated the team met and decided we will assume the worst, like maybe somebody is hitting her, maybe she's having rough treatment. The administrator stated if he suspected abuse of a resident had occurred it was his responsibility to immediately report it and start an investigation. He stated there was previously a nurse manager, RN-A, who assisted with the investigation into R2's postings. The administrator noted RN-A spoke to R2 immediately to ask her if she was safe and if anyone was hurting her and did a head-to-toe skin assessment with no findings. The administrator noted at the IDT meeting the IDT decided to put a camera inside of R2's room but R2's family and partner did not want this or sign the consent forms, so no camera was placed. The administrator indicated staff decided to keep watching R2 and monitoring her behaviors and what she said. He stated RN-A was supposed to document what she investigated in a progress note and concern report and document the interview of R2. He identified the documentation as incomplete. The administrator stated he thought the social worker interviewed other residents to see if they felt safe but information about what the interviews were, who was interviewed, and if staff were interviewed was missing. In an interview on 5/23/24 at 1:08 p.m., SS-A stated she spoke to some residents on R2's floor after she found out about the posts but many on the floor are vegetative. SS-A identified four residents she thought she spoke to and stated she did not think she documented the interviews. She stated she did not interview staff, she thought the administrator was going to talk to staff. Documentation of resident and/or staff interviews was requested, but not received. An alternative form of safety assessment for vegetative residents was not noted. In an interview on 5/23/243 at 2:00 p.m., the director of nursing (DON) stated with R2's post of womanhandheadpunchicried she would be concerned about abuse. The DON stated she did not recall how she became aware of the situation. She stated the nurse manager for that unit [RN-A] was going to follow up and she did some brief initial follow up and had been given direction that this needs to be investigated. I think it was on a Friday and then on Sunday she ended her employment with us . I can't tell you exactly what she investigated, can't say if it was thorough. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy titled Abuse Prevention Plan with last revision date 7/21/22, included Investigation of incidents and allegations: a.) All accident and incidents as well as allegations of abuse, neglect, misappropriation of resident property, and/or financial exploitation will be thoroughly investigated by the Director of Social Services, Director of Nursing, or their appropriate designees .; b.) Measures will be taken to identify the source of the alleged abuse and prevent future incidents; c.) Investigative packets will be utilized to systematically direct the team through the investigative process; d.) Any evidence gathered will be handled with caution to ensure no tampering, destruction, or alteration occurs. Facility staff conducting the investigation will take care to only share information about the incident or investigation with other staff who have a professional 'need to know;' e.) Identify and interview all who might have knowledge of the incident including the alleged victim, perpetrator, witnesses or others who may have had related contact with the alleged perpetrator, related to the incident in question; f.) The focus of the investigation is to determine the extent, cause and future prevention with thorough documentation of the investigative process completed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to comprehensively assess pressure ulcers and provide necessary treatment and services to prevent and/or mitigate the risk of new ulcer development or deterioration resulting in actual harm with the development of a new pressure injury for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: Definitions of pressure ulcer types Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis (middle layer of skin), presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Fat is not visible and deeper tissues are not visible. Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (non-viable usually moist tissue than can be soft and stringy in texture) and/or eschar (dead or devitalized tissue that is usually black and may appear scab-like) may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia (connective tissues), muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable pressure ulcer. Unstageable Pressure Ulcer: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE] from a hospital and had diagnoses including unspecified displaced fracture of first cervical vertebra (broken neck), anemia (lack of healthy red blood cells), septicemia (sepsis), stroke, quadriplegia, respiratory failure, stage 2 pressure ulcer of right buttock, unspecified convulsions, and dependence on ventilator status. R1 was rarely/never understood and rarely/never understood others, had severely impaired cognitive skills for daily decision making, had range of motion limitations in all extremities, and was fully dependent on staff for cares such a mobility in bed, transferring, and hygiene. R1 had an indwelling urinary catheter, was always incontinent of bowel, got 51% or more of total calories through a feeding tube, utilized supplemental oxygen, was on an invasive mechanical ventilator, and needed tracheostomy care. R1's MDS identified him as at risk for developing pressure ulcers and noted one stage 2 pressure ulcer present on admission with treatments of a pressure reducing device for chair and bed, pressure ulcer care, and the application of nonsurgical dressings other than to feet. R1's post-discharge instructions from the discharging facility dated 4/10/24, included Miami J collar [a cervical collar/brace to stabilize cervical neck injuries] in place due to diagnosis of C1-C4 [cervical vertebra one through four] fracture incomplete quadriplegia. It did not include orders or instructions regarding management of the collar, note any active wounds, or include orders for wound care. A progress note dated 4/12/24, indicated R1 arrived at the facility the previous evening at 7:38 p.m. and had a cervical collar on as well as wound on both buttock/coccyx, with left buttock wound measuring 3 centimeters (cm) long by 0.7 cm wide and right buttock wound measuring 2.5 cm long by 1 cm wide. The note included clean[ed] with NS [normal saline] and foam dressing applied. It lacked comprehensive assessment of both wounds that identified risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition, hydration, pressure points for turning and reposition needs, wound bed characteristics, drainage and pain. R1's Skin Risk Observation with Braden Scale dated 4/12/24, indicated R1 had one of more unhealed pressure injuries at stage 1 or higher. The location(s) of the observed pressure injuries was buttock R/L [right/left]. R1's Braden Scale for Prediction of Pressure Sore Risk indicated he was at a high risk level. It lacked further assessment of the identified wounds. A provider note by nurse practitioner (NP)-A dated 4/12/24 and 4/16/24, both noted no skin breakdown. They also noted Incomplete quadriplegia since 11/2023. Has a collar in place. Plan: will need neuro[logy] follow up with xrays [sic]. R1's provider orders included an order dated 4/16/24, noting resident has a Miami [NAME] [sic] collar. Special instructions: NP will address after review of chart. R1's provider orders included an order dated 4/16/24, for wound care: sacral area foam dressing every shift until wound nurse assessment. R1's electronic health record (EHR) lacked wound care orders for the sacral wound prior to 4/16/24. R1's Treatment Administration Record (TAR) dated 4/1/24 to 4/30/24, indicated the sacral wound care treatment was first documented as complete on the first shift of the day on 4/16/24. R1's TAR lacked documentation of wound care treatments for the sacral wound prior to 4/16/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Wound Management Detail Report by the facility's wound nurse dated 4/17/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 2.8 cm long, 2.5 cm wide, and 0.1 cm deep with no exudate (drainage) or odor, was a stage 2, had no undermining or tunneling, irregular wound edges, 100% epithelial tissue, blanchable redness of the skin surrounding the wound, and wound healing status was stable. Comments noted peri-wound skin fragile. The wound report did not address the pressure ulcer on the left buttock previously identified on left buttock. R1's Care Area Assessment (CAA) for pressure ulcer/injury dated 4/22/24, identified R1's risk factors for pressure ulcer/injury. Extrinsic risk factors included: requires staff assistance to move sufficiently to relive pressure over any one site, confined to a bed or chair all or most of the time, needs special mattress or seat cushion to reduce or relieve pressure, slides down in the bed, and persistently wet (especially from fecal incontinent, wound drainage, or perspiration). Intrinsic risk factors included: immobility, cognitive loss, incontinence, and poor nutrition. Medication risk factors included opioid medications. Diagnoses or conditions that presented complications or increased risk included: cerebrovascular accident (stroke), paraplegia/quadriplegia, edema, sepsis, pain, and recent decline in functional abilities. Treatments and other factors that caused complications or increased risk included: newly admitted or readmitted , history of healed pressure ulcer/injury, ventilator or respirator, functional limitation in range of motion, head of bed elevated most or all of the time, and devices that can cause pressure (such a oxygen or indwelling catheter tubing, TED (compression) hose, casts, or splints). The analysis of findings noted admitted [with] pressure ulcer and pressure ulcer risk with contributing factors above. At risk for further clinical declines, increased burden of care, discomfort if this does not heal or further breakdown occurs. R1's Wound Management Detail Report by the facility's wound nurse dated 4/24/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 2.3 cm long, 2 cm wide, and 0.1 cm deep with a light amount of bloody (bright red, thin) exudate, no odor, was a stage 2, had no undermining or tunneling, had wound edges epithelializing flush with the wound base, 100% epithelial tissue, blanchable redness of the skin surrounding the wound that was dry and thin, and wound healing status was improving. Comments noted Smaller. Peri-wound skin has fragile areas. Hydrocolloid covers [a type of dressing for wounds]. R1's care plan for pressure ulcer/injury dated 4/26/24, noted I have a current pressure ulcer (admitted with) located buttock/sacral area. I am at risk for increased skin integrity issues due to incontinence, immobility, use of equipment and medications, anemia. Goal dated 4/29/24, noted my pressure ulcer will continue to show sings of healing and no new areas will develop through the review date with interventions dated 4/26/24 including assisting with repositioning every two to three hours with use of an air mattress for pressure relief and need for head of bed elevated for tube feeding and ease of breathing, nursing assistants (NA's) observing skin and reporting any abnormalities to the nurse, having good skin hygiene and skin to be moisturized as needed if dry, elimination of waste to be addressed in the toileting section of the care plan, monitoring of labs and weight as ordered, pressure redistributing mattress on bed and cushion in chair, proper notifications to be made if wounds change, staff providing adequate nutrition and hydration with nutritional supplements and vitamins as ordered, using pillows between knees and bony prominences to avoid direct contact, and treatments as ordered (see TAR). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A provider note by nurse practitioner NP-A dated 4/26/24, noted no skin breakdown. It also noted Incomplete quadriplegia since 11/2023. Has a collar in place (wife reports C2 [second cervical vertebra] was not healing and that is why collar was left in place in Arizona [R2 admitted to facility from a hospital in Arizona]). Plan: will need neuro[logy] follow up with xrays [sic] and referral to [local hospital] neurosurgery. A neurosurgery clinic provider note dated 4/30/24, noted R1 was seen for consideration of weaning of collar and noted due to the complexity of the patient's recent hospital course, would like to review chart in more detail prior to discontinuing collar. Instructions included follow-up on Thursday at 8:30 a.m. and orders placed at the visit were for a computed tomography (CT) scan. R1's Wound Management Detail Report by the facility's wound nurse dated 5/1/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 3 cm long, 6 cm wide, and the depth could not be measured with a moderate amount of serosanguineous (pale red to pink, thin and watery) exudate, no odor, was a stage 3, no undermining or tunneling, had irregular wound edges, was 60% covered by epithelial tissue and 40% covered by slough tissue (dead tissue usually cream or yellow in color), skin surrounding the wound had blanchable redness, and the wound healing status was declining. Comments noted Larger area of denuded [exposed, damaged] skin. R1's wound was identified as a stage 3 pressure ulcer whereas previous Wound Management Detail Reports from 4/17/24 and 4/24/24 had identified this wound as stage 2. R1's Wound Management Detail Report by the facility's wound nurse dated 5/1/24, included a pressure ulcer with location of coccyx center; superior not present on admission with date identified of 5/1/24. The wound was 2.7 cm long, 1.1 cm wide, with depth that could not be measured, no odor or exudate, was a stage 3, had no undermining or tunneling, the wound was 90% covered by slough tissue and 10% covered by epithelization tissue, had well defined wound edges with pink/normal surrounding skin, and the wound healing status was stable. Comments noted covered with hydrocolloid along with other open area. R1's skin care plan did not include any revisions upon identification of the worsening pressure ulcer of the right coccyx. Further R1's record did not include a comprehensive assessment of the center superior coccyx wound identified on 5/1/24 that included risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition, hydration, pressure points for turning and reposition needs, and pain. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 5/23/24 at 1:10 p.m., the assistant director of nursing (ADON) confirmed R1's admission progress note dated 4/12/24 identified sacral pressure ulcers on both the left and right sides with placement of a foam dressing and wound care orders that started on the 16th with the order for a sacral area foam dressing every shift. The ADON stated she did not see any evidence of wound care between 4/12/24 and 4/16/24. She noted that if a resident arrived with wounds but no wound care orders, staff should request orders from the provider and this did not meet her expectation for wound care nor was it in line with standards of care. The ADON identified that a pressure ulcer not being treated had the potential to worsen. The ADON stated comprehensive assessment of wounds were completed by the facility's wound nurse who rounds weekly on Wednesdays. She confirmed that the wound nurse saw R1 on 4/17/24 and documented the right coccyx pressure wound but did not document the second wound previously identified in the 4/12/24 progress note until a visit on 5/1/24 when it was first comprehensively assessed. The ADON stated the wound should have been assessed as soon as it was identified and by the wound nurse when she saw R1 on 4/17/24. The ADON confirmed documentation indicated R1's right coccyx pressure ulcer progressed from a stage 2 wound on 4/24/24 to a stage 3 wound on 5/1/24 and she would want a resident's care plan, orders, and interventions to be updated for a worsening wound and did not have any evidence that interventions were re-assessed for effectiveness when staff identified the wound was worsening. A provider note by nurse practitioner NP-A dated 5/2/24, indicated R1 had a change in condition and NP-A recommended sending him to the hospital for further evaluation and diagnosis. A progress noted dated 5/2/24, indicated R1 was transported to the emergency department via emergency services at approximately 11:30 a.m. A hospital patient care image (photograph) in R1's EHR dated 5/2/24 at 1:42 p.m., depicted a large open wound on the back of the head with description of mechanical pressure ulcer back of head from c collar [cervical collar]. Additional photographs depicted a foam border dressing with the date 3/18 visible on the front in marker and the back of the dressing with a large amount of bloody drainage, hair, and skin attached after removal from R1's head. A hospital intensive care unit admission note dated 5/2/24 at 1:44 p.m., included open wounds on his occipital area and coccyx (pictures in chart). A hospital progress note dated 5/2/24 at 2:03 p.m., noted patient malodorous, has foam bandage to back of head that is grossly bloody with layers of skin, wound under occiput in same shape and depth of dressing dated 3/18 as in March 18. Today's date is May 2nd. Unable to currently visualize skin under Miami J. Wound nurse consult placed stat as well. A hospital wound nurse consultation note dated 5/3/24 at 8:10 a.m., identified a pressure injury on the posterior head noted to be unstageable and a pressure injury located on the sacrum with poorly defined/irregular margins noted to be a deep tissue injury. Review of R1's record throughout his admission to the facility prior to transfer to the hospital lacks any documentation of a wound on the posterior head. Nursing Home Incident Report #356410 submitted to the State Agency by the facility dated 5/4/24, noted resident [R1] was sent to the hospital for evaluation. At the hospital resident was noted having a pressure related ulcer at the back of his head. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nursing Home Incident Report Investigation Report Summary #356410 submitted to the State Agency by the facility dated 5/10/24, noted staff did not have orders for management of Miami J Collar, and were waiting for [physician]/NP to decide on management. In an interview on 5/23/24 at 7:26 a.m., registered nurse (RN)-D stated R1 had a cervical collar secured with Velcro and they would undo the Velcro to change his tracheostomy ties (a strip of material that goes around someone's neck to assist with securing a tracheostomy tube on the front of the neck). RN-D noted staff did not have an order for the collar and it said in the computer that it would be evaluated by the provider to determine how to manage it. RN-D stated nurses needed an order to remove the collar to clean the skin underneath and because she saw that the collar was to be evaluated by the provider she thought they would come and do something. RN-D stated she did not know what the manufacturer recommended for management of the Miami J cervical collar. In an interview on 5/23/24 at 8:21 a.m., RN-B stated residents with neck braces admit to the facility with instructions from the doctor about the brace that staff followed. She noted if someone had a brace sometimes they might get a wound, like if the brace is not ever released, if it is tight, or if there is already a wound underneath that needs to be dressed, so you have to always assess . you have to see if it is making a wound from the pressure, you have to check the skin. RN-B stated to check the skin nurses could remove the brace if there was an order to do so but, if not, could look and feel inside the space between the back of the head and the brace to assess the skin. RN-B noted that if someone had a brace but no orders she would call the provider to request orders, if someone had a pressure ulcer but no wound care orders she would assess the wound and call the provider to request orders. In an interview on 5/23/24 at 8:53 a.m., RN-C stated for a resident with a cervical neck brace the first thing is you need to assess the skin under the collar and see what's going on . you remove it and then put it back on when you're done and check to see if the collar is clean on the inside too. RN-C further stated if a resident with a collar comes in, it doesn't matter if there is an order or not, you have to assess the skin. If you think it's not safe to remove the collar and do the assessment then you need to let the provider know that you need an order so you can assess. RN-C states if a resident had a pressure ulcer but no wound care orders nurses have to assess it and tell the provider, it was not okay to just leave it, nurses had to ask for orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/23/24 at 11:01 a.m., the administrator stated R1 was admitted on [DATE] with a Miami J collar and staff immediately realized they did not have orders for the management of the collar. The administrator noted staff contacted the discharging facility and requested orders the next day but did not receive them. He stated R1 had a provider visit on 4/12/24 and nursing requested orders from NP-A, but NP-A and the doctor said they could not give the orders and R1 needed to be referred to neurology for this. He noted a referral was made and appointment scheduled for 4/30/24. The administrator stated that after the referral was made the question arose of whether we should take the collar off and see the skin under, but the family said that we should not touch the collar because his C2 hadn't healed and it was very dangerous. He stated they waited and at NP at the neurology clinic saw him on 4/30/24 but was not comfortable giving any orders for management of the collar. The administrator noted that the facility had access to the hospital's medical record system and became aware after R1 was transferred to the hospital that hospital staff identified a wound under the Miami J collar. The administrator stated nurses need to do a thorough job in assessing skin and although they did not have orders to move the collar, maybe they should have sent R1 in faster for evaluation of the collar, maybe to the emergency department rather than wait for a neurology appointment. He noted attempts were made to get orders for management of the collar, but doctors were not willing to provide them and the mistake initially happened when R1 was admitted without complete orders. The administrator stated that accepting a resident for admission with complete orders was a mistake because once the facility accepted the resident they became the facility's responsibility. In an interview on 5/23/24 at 1:10 p.m., the assistant director of nursing (ADON)stated she was not aware during his admission that R1 had a wound on the back of his head. She noted head to toe skin assessments are done on admission but R1's did not identify a head wound. The ADON noted for someone like R1 with skin underneath a medical device she would expect to have orders for management of the device and would expect staff to have an order to remove a cervical collar. She further noted that staff could have at least felt behind the collar to check R1's skin in the absence of orders to remove the collar for skin assessment. In an interview on 5/23/24 at 2:00 p.m., the director of nursing (DON) stated the facility lacked orders for R1's cervical collar she wouldn't dare remove it without having direction which is why NP-A referred R1 to neurosurgery. The DON noted she expected comprehensive skin assessments and getting needed orders to be done within 24 hours of admission. She stated comprehensive assessments of wounds and documentation of all the wound characteristics were needed to track wound healing and should be done within the first couple days after a wound was identified. She confirmed that a wound identified on a Thursday (4/11/24) that was not comprehensively assessed until the following Wednesday (4/17/24) was not in line with her expectations or professional standards of practice. The DON noted that the facility had been informed in R1's pre-admission assessment that he did not have any wounds but if someone had a wound and no wound care orders staff should initiate wound care per facility protocol and contact the provider for further orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/23/24 at 2:39 p.m., NP-A stated for someone with a cervical collar typical standards of care are that the facility would have some orders for it from the discharging facility. She stated typically the facility would have orders directing to leave a collar on for a specific amount of time or to remove it and clean underneath it, but they didn't have a lot of data from the discharging facility about R1 and his collar. NP-A noted she referred R1 to neurosurgery to et an x-ray and orders for the collar for specialist to make a recommendation about what to do. She stated expectations for skin assessment with R1 were tough, if staff had asked her if it was okay to remove to collar and look at the skin underneath she probably would have deferred to the physician because the facility did not have good records and they were going off of what family said. NP-A stated staff probably wanted me to say let's take off the collar and look at the skin, but we never had that specific conversation about looking at the skin. The question was what do we do with the collar and my answer was send him to neurosurgery. I think we all own a piece of this . I'm a wound care nurse and I turned him over and looked at his bottom but I didn't take the collar off, didn't see the back of his head . I was aware that we weren't taking the collar off because we agreed neurosurgery needs to evaluate him. NP-A noted that she first saw R1 on 4/12/24 and did not note any skin issues but knew he had a little area on his bottom and states I recall seeing small areas on his bottom, one comes to mind, but I can't say for sure. They were like superficial. In an interview on 5/29/24 at 11:50 a.m., the facility's medical director (MD) stated, if a resident admitted with a cervical collar it would always be left on until staff could obtain orders for its management because staff needed doctor's orders to remove a cervical collar. The MD noted R1 did not have orders for management of his Miami J collar on arrival so staff attempted to get orders from the referring hospital, the primary care team, and the neurology clinic. The MD stated the facility did not receive complete information about R1's care needs and somebody had previously put a dressing on a wound underneath the collar but never recorded it for facility staff to see, so they had no knowledge there was an open area or that there was a dressing in place. The MD identified this as a bad outcome and noted nursing staff are responsible for skin care once a resident arrives at the facility. The MD stated he did not have a clear timeline for how long a resident could go without orders for a cervical collar before he would expect alternative interventions, like sending the resident to the emergency department. The MD stated he did not have an answer regarding if he would expect nursing staff to consult manufacturer guidelines for a cervical collar. Miami J Patient Care Handbook from manufacturer Ossur copyrighted 2010, includes C-Spine Precautions: you must be lying flat to remove the collar unless your doctor gives you permission to do this in a sitting position. You will need a second person to help you in order to maintain the proper head, neck, and airway alignment. Position patient with arms to the side, shoulders down and head aligned centrally. Unless otherwise specified by your doctor: do not remove the collar except to wash under it and change the pads. Keeping your Miami J and the skin beneath clean is an important part of your treatment. Daily cleaning will help to prevent skin irritation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility policy titled Prevention and Treatment of Skin Breakdown dated 2018, included Policy: Resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. Treatment of impaired pressure injury and lower extremity ulcers (arterial, venous, neuropathy/diabetic, mixed) If a resident is admitted with impaired skin integrity or a new pressure injury or lower extremity wound developed the licensed nurse implements the following items: 1.) Documentation of the skin impairment is completed in the medical record. Staging of pressure injury is completed as necessary by trained licensed associated. Other lower extremity wounds with [sic] be described a partial thickness loss or full thickness loss. 2.) Standing orders/protocol for skin wound are initiated. 3.) Notify attending provider, resident and resident representative. Attending provider determines wound type and may provide additional orders. 4.) Notify supervisor/designee. 5.) Evaluate current pressure reduction interventions and revise resident centered care plan. Facility policies an admission orders and skin protocol were requested but not received.

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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** 42355 Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBPs) for 2 of 3 (R3 and R4) residents observed for ventilator (machine that breathes for residents) tracheostomy residents, residents who had feeding tubes or indwelling urinary catheters. Findings include: R3's 5-day Minimum Data Set (MDS) dated [DATE], indicated R3 was in a persistent vegetative state and had diagnoses of traumatic brain injury, neurogenic bladder, history of multidrug-resistant organism (MRDOs), pneumonia, septicemia, seizure disorder or epilepsy and respiratory failure. R3 was dependent for all activities of daily living (ADLs). R3 had a tracheostomy and with invasive mechanical ventilator and required suctioning. R3 received tube feeding for nutrition and had an indwelling urinary catheter. Review of R3's care plan did not address R3's risk for infection nor interventions for infection prevention that included the use of personal protective equipment (PPE). During continuous observation on 5/23/24 between 11:15 a.m. and 1:10 p.m., the entrance to R3's room did not have signage posted that identified EBP nor a PPE cart outside/inside the room was in his room. R3 was lying in his room during this time. Nursing assistant (NA)-R and registered nurse (RN)-C entered R3's room to perform care tasks that included, bathing, suctioning of tracheostomy, urinary catheter cares and wound dressing changes. Neither staff members were observed using gowns during these activities. R4's quarterly MDS dated [DATE], indicated R4's cognition was not assessed however, the annual MDS dated [DATE], indicated R4 had severely impaired cognition. R4's MDS dated [DATE], identified R4 had diagnoses of high blood pressure, neurogenic bladder, diabetes, aphasia, problems swallowing), hemiplegia/hemiparesis (paralyzed on side), seizure disorder or epilepsy and respiratory failure. R4 was dependent for all ADLs. R4 had tracheostomy with invasive mechanical ventilator and required suctioning. R4 received tube feeding for nutrition and had an indwelling catheter. Review of R4's care plan did not address R3's risk for infection nor interventions for infection prevention that included the use of PPE. During an observation on 5/23/24 at 1:36 p.m., RN-E and NA-S performed cares for R4 which included tracheostomy suctioning, indwelling urinary catheter cares, including emptying the urine collection bag, peri care and wound dressing changes without wearing gowns. During an interview on 5/23/24 at 2:07 p.m., RN-E stated staff never wore gowns for catheter cares, ventilator and tracheostomy cares, and during wound cares unless resident's were on contact precautions. RN-E was not aware of what EBP were and when they should be implemented. During an interview on 5/23/24 at 2:09 p.m., RN-C was not aware of what EBP were and when they should be implemented. RN-C stated the staff would only use gowns with contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 2:33 p.m., assistant director of nursing (ADON) indicated the facility was in the process of implementing EBP's. During an interview on 5/23/24 at 3:03 p.m., nurse practitioner (NP)-A was not aware of when EBP should be implemented. During an interview on 3/22/24 at 11:48 a.m., Administrator stated residents with implanted medical devices, would need EBP's. These have not been set up and the facility was in the process of implementation these regulations. Review of facility policy dated 2019, titled Enhanced Barrier Precautions, -purpose was to be a strategy in nursing homes to decrease transmission of center for disease control (CDC)- targets and other important MRDOs. Resident at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing change will be required to use EBP. -Policy table on when to use EBPs to be used with all residents with any of the following Indwelling medical devices (e.g., urinary catheters, feeding tubes, tracheostomy/ventilator), regardless of MDRO colonization status. Required personal protective equipment (PPE), gown, gloves prior to high contact care activity. Face protection may also be needed if performing activity with risk of splash or spray. -General considerations when using EBPs indicated 4.) post clear signage on the door or wall outside resident room indicating the type of precautions and required PPE. 5.) make PPE available in a designated area outside resident room, 7.) position a trash receptacle inside the resident room and near the exit for the PPE to be discarded prior to exiting the room. 8.) Provide education to staff, residents and visitors as needed. 49338