STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245290	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Olivia Restorative Care Center	1003 West Maple Avenue Olivia, MN 56277

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 - Minimal harm or potential for 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** 42355 Based on observation, interview, and record review the facility failed to follow physician ordered wound treatments and failed to ensure appropriate infection control practices during wound care including hand hygiene to prevent or mitigate the risk of wound deterioration and/or infection for 2 of 2 residents (R2, R3) reviewed for pressure ulcers. Findings include: R2's admission Minimum Data Set, dated dated dated [DATE], indicated R2 had moderate cognitive impairment, with diagnoses of peripheral vascular disease or peripheral artery disease. R2 required substantial assist with all activities of daily living (ADLs) except for oral hygiene. R2 had no pressure ulcers, arterial, venous ulcers, or other skin problems. R2 had pressure relieving devices on bed and chair and received nutrition or hydration interventions to manage skin problems. R2's skin integrity care plan dated 1/9/24, indicated R2 had potential/actual impairment to skin integrity, with the following interventions: -Barrier cream (dated 1/9/24), -The resident needs pressure relieving/reducing cushion to protect the skin while up in chair (dated 2/5/24). -The resident needs pressure relieving/reducing mattress to protect skin while in bed (2/5/24). R2's physician orders indicated the following orders: -Weekly skin checks and complete assessment every Sunday day shift for monitoring (dated 1/2/24). -Wound care: right knee- cleanse with wound cleanser, pat dry, paint with Betadine daily. Avoid pressure or trauma (dated 2/22/24). -Wound Care right heel pressure wound: 1) cleanse area with wound cleanser and pat dry. 2) Apply skin prep and allow to dry. 3) Apply collagen powder. 4) Cover with a foam heel dressing and wrap with Kerlix. 5) change every 3 days and PRN. Notify provider and wound nurse with any concerns or sings and symptoms/ of infections (Dated 3/2/24). (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor right shin abrasion, clean with wound cleanser, pat dry, apply triple antibiotic ointment, cover with band aid, twice daily and as needed. Avoid pressure or trauma (Dated 3/7/24). -Monitor skin tears to left arm daily, apply dressing as needed until healed (Dated 3/12/24). During an observation on 3/13/24 at 10:04 a.m., registered nurse (RN)-C entered R2's room with a wound kit that contained various wound supplies and set it on top of R2's bed side table without first placing a barrier. RN-C completed R2's dressing changes as follows: RN-C explained to R2 what he was doing and assisted R2 to remove his right tennis shoe and light green gripper sock. RN-C applied gloves and removed the large band aid to R2's right lower inner shin, there was a small amount of yellow drainage noted on the old band aid. RN-C indicated he needed to go get more band aides and left the room without performing hand hygiene. RN-C returned to the room and applied gloves. RN-C then reached into the wound kit and removed 4x4's and the wound cleanser. RN-C sprayed the 4x4 with wound cleanser on a 4x4, laying the wound cleanser on a folding chair, without a barrier, RN-C then wiped the right lower shin wound with the 4x4. RN-C, with the same gloves on reached into the wound kit and took out the triple antibiotic ointment. RN-C took off his gloves, applied new gloves without performing hand hygiene, put ointment on his gloved finger, and applied it to R2's wound. RN-C then recapped the ointment and placed it back into the wound kit. With the same gloves on RN-C applied large band aide to R2's wound, removed his gloves, and marked the date and initials on R2's dressing. RN-C left the room to obtain more gloves and returned to the room. R2 stated he was having some pain in right heel area as RN-C removed the dressing to the back of right heel, with the same gloves on. The right heel wound was about 3.5 cm diameter of peeling periphery skin around a 1.5 cm open area white in color moist looking in the center. RN-C used the wound cleanser that was sitting on the chair beside him, sprayed a 4x4 with the wound cleanser, and cleansed the wound with the 4x4, laid the wound cleanser on R2's bed without a barrier present. RN-C cleansed the wound again and with the same gloves on, RN-C reached into the wound kit and obtained one betadine swab packet. Applied the swab to the outside edge of the wound and worked his way to the center of the wound. Threw the swab into the garbage can. RN-C reached again into the wound kit, with the same gloves on and obtained a second betadine swab package. RN-C repeated the process with a second swab, from the outside edge to the center of the wound. RN-C then left the wound open to air. RN-C removed his gloves. RN-C then without gloves on and without performing hand hygiene, applied the light green gripper sock and shoe and did not cover the left heel wound with a dressing according to physician's orders. R2 asked RN-C about his left arm where there were gauze wraps to his forearm and elbow area. RN-C stated that there was not a dressing change order for those areas and did not address. RN-C put all materials back into the general wound kit and put the cover on. RN-C left R2's room, walked to the nurses' station and placed the general kit back into a cupboard without disinfecting the outside of the kit. During an interview on 3/13/24 at 11:35 a.m., RN-C stated he looked at the wound care orders on the computer at the nurses' station, wrote them on a piece of paper and then went to the resident's room with the wound kit to do dressing change. RN-C reviewed R2's dressing change orders and stated he only completed the right shin and heel dressing and had not followed the dressing change orders and identified he had not performed appropropriate hand hygeine. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's significant change MDS dated [DATE], had diagnoses of stroke, deep vein thrombosis, and diabetes. R3 was at risk for pressure ulcers, but did not have pressure ulcers, arterial, venous ulcers or any skin concerns noted. R3 did have pressure reducing devices for bed and chair, was on a turning and reposition schedule, and received nutrition or hydration interventions to manage skin problems. R3 had range of motion impairment on one side of her body, used a wheelchair, was dependent with all transfers, toileting hygiene, shower/bathing and putting on her footwear. R3 required extensive assistance with dressing and personal hygiene. R3 did not walk. R3's skin care plan 10/6/23 included: R3 has diabetic ulcer of the right foot related to diabetes, lack of sensation to affected area, and vascular insufficiency. Interventions included but was not limited to, -Monitor pressure areas for color, sensation and temperature, dated 10/6/23 -monitor, document wound size, depth, margins peri wound skin, sinus, undermining, exudates edema, granulation, infection, necrosis, eschar gangrene. Document progress in wound healing on an ongoing basis. Notify MD as indicated, dated 10/6/23, -Weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observation, dated 10/6/23. R3's physician orders included: -Ted socks (elastic compression socks) on in AM off at bedtime, dated 10/13/23, -Wash and dry feet and apply lotion twice daily. Do not apply lotion between toes. Notify wound nurse with skin issues or concerns, dated 12/24/23, -Weekly skin checks and complete assessment, every Tuesday evening shift, dated 9/29/23, -Wound care: bottom of right foot. Cleanse with wound cleanser apply alginate (a special dressing to promote healing), apply boarded foam dressing. If worsens, notify wound nurse. Change daily and as needed, dated 2/11/24. During an observation on 3/13/24 at 11:12 a.m., RN-C enter R3's room. R3 was sitting in her recliner by the window. RN-C set the wound kit and two packages of Maxsorb (an alginate dressing material) on the bedside stand next to R3 without a barrier between them. RN-C applied gloves and then removed R3's red right gripper sock and pulled her open toe TEDS (compression stocking) up to mid foot. RN-C removed the tan Mepilex dressing from R3's right bunion area. There was bright red blood noted on dressing. RN-C stated he could not see where the blood coming from. RN-C grabbed the wound cleanser and 4x4's from the wound kit without changing his gloves. He sprayed the cleanser on the 4x4 and set the wound cleanser on the floor, with no barrier between. RN-C grabbed more 4 x 4's from the wound kit, sprayed the 4 x 4's and the wound area, and then set the wound cleanser on the floor again. RN-C changed his gloves, cut a piece of Maxsorb placed it on the wound, then placed a new Mepilex (boarder foam dressing) over the wound. RN-C then picked up the wound cleanser from the floor and put it back into the wound kit. He then put the lid on the kit, removed his gloves, grabbed the garbage bag and left the room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/24 at 12:19 p.m., RN-B stated with the facilities own staff she provided infection control training, but RN-C was temporary agency staff and was not aware of specific training he had. RN-B stated there should be a barrier between the kit/supplies and the surface they were setting them on as because it prevents cross contamination. RN-B explained wounds were cleaned from the inside of the wound to the outside to prevent contamination of the wound bed. RN-B stated that the nurses working the floor were to look at the wound/dressing orders before they perform the treatments and follow the physician orders. During interview on 3/13/24 at 2:25 p.m., Wound Ostomy Consultant Nurse Practitioner (WOC)-A stated the use of betadine was to clean and dry out wounds. WOC-A did not think the use of it on R2's right heel would have harmed the wound but it was the wrong treatment. With it being the wrong treatment, it could slow down the healing process of this already chronic wound. WOC-A stated a barrier between supplies and the surface important to prevent cross contamination. WOC-A explained the proper way to clean wounds was from the inside (middle) of wound toward the outside, to prevent contamination of the wound. It was her expectation orders for wounds are followed as written. During interview on 3/13/23, at director of nursing (DON) stated it was her expectation the staff carried out the physician orders as written and per the facilities dressing protocol for infection control purposes. Review of facility policy titles Wound Care dated October 2010, indicated in the steps in the procedure: 1. Use disposable cloth (paper towel is adequate) to establish a clean field on resident's over bed table. Place all items to be used during procedure on the clean field. Arrange supplies so that they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect bed linen and other body site. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptable. Wash and dry your hands thoroughy. 6. Put on gloves. Gowns wil only be necessary if soiling of your skin or clothing with blood, urine, feces or other body fluids is likely . 7. Use no touch technique by using tongue blades and applicators to remove ointments and creams frm their containers. 9.Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. (continued on next page)

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