STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245341	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Centracare Health System-Sauk Centre Nursing Home	425 N Elm Street Sauk Centre, MN 56378

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** 43083 Based on interview and document review, the facility failed to document assessments that occur during pressure ulcer dressing changes to include measurements and visual data and have a system to ensure appropriate reporting with findings and follow up occurred when the need for a more thorough assessment was identified for 1 of 1 resident (R1). Findings include: R1's admission Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of osteomyelitis of vertebra (infection in a bone), extradural and subdural abscess (area of pus located in brain), severe protein-calorie malnutrition, acute infarction of spinal cord (stroke within the spinal cord), and a pressure ulcer. R1's care plan dated 9/5/24, indicated R1 had a deep tissue pressure ulcer to coccyx. Staff were to administer pain medications as directed, observe for signs and symptoms of pain with treatments, ensure an air mattress was on his on bed, assist/encourage R1 to float his heels while in bed, ensure a foot cradle was in place to offload pressure, provide nutritional supplements as ordered, observe for signs or symptoms of infection, and reposition side to side every 2 hours. There was no mention staff were to document findings when providing ordered dressing changes. R1's Weekly Complex Wound assessment dated [DATE], identified R1 had an unstable pressure wound located on coccyx measuring 11 centimeters (cm) long, 2.7 cm wide, and depth was 0.3 cm. Further assessment identified moderate amount of serous (thin, watery, clear drainage) exudate, slight odor present, 10% granulation tissue (pink or red tissue with shiny, moist, granular appearance), 40% slough (yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or mucinous), and 50% necrotic tissue (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges). R1's wound was noted to have 0.3 millimeters (mm) tunneling at 6 o'clock. R1 was scheduled to have a wound consult on 8/22/24. R1's physician was notified. R1's Medication Administration Record (MAR) for August 2024, revealed R1 had a wound treatment order which was Mepilex 6x6 to coccyx ulcer three times a week and as needed if soiled. R1's Treatment Administration Record (TAR) identified dressing changes and wound treatments were completed on 8/16/24, 8/19/24, and 8/21/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245341	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2024
NAME OF PROVIDER OR SUPPLIER: Centracare Health System-Sauk Centre Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 425 N Elm Street Sauk Centre, MN 56378	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's progress notes identified no corresponding treatment note, originating for the TAR was made on 8/16/24, 8/19/24, or 8/21/24 that would identify characteristics of the pressure ulcer, changes that were identified by licensed staff, or notification for the need for a formal assessment due to changes in the wound. R1's medical record lacked evidence of a any wound assessment on 8/16/24, 8/19/24, or 8/21/24, when R1's wound treatment was completed. On 9/17/24 at 1:08 p.m., licensed practical nurse (LPN)-A stated as a licensed nurse if she was made aware there was a change with a resident's wound, she would complete an assessment and notify the director of nursing (DON) with the information as well as informing the resident's physician. LPN-A stated upon notifying management, they would complete a comprehensive assessment on the wound and assess the wound more thoroughly. LPN-A stated R1 was admitted to the facility with a sacral wound. LPN-A stated she observed R1's wound on Friday 8/16/24, and again on Sunday 8/18/24, and LPN-A stated the wound looked worse and notified registered nurse (RN)-A and DON via email. LPN-A was unsure what happened after that but assumed RN-A re-assessed R1's wound on Monday 8/19/24. In addition, LPN-A could not recall if she documented the wound in R1's medical record regarding identified changes she made during her observations while providing wound care. RN-A was no longer employed by the facility at the time of survey and was unavailable for interview. On 9/17/24 at 4:25 p.m., DON stated R1 was admitted to the facility with the wound on his coccyx. The DON was made aware the need for a formal assessment via email from LPN-A regarding a concern of R1's wound potentially worsening but could not recall what the email said specifically. It was addressed to RN-A and the DON had been cc' d on the email. DON stated there was no evidence in R1's record of R1's wound being re-assessed after the change was identified by LPN-A, nor was there documentation to support her visual assessments at the time dressing changes were performed had been documented. Staff were expected to re-assess a change in a wound, document the assessment, and add progress notes identifying changes or current status of wounds. Further interview on 9/17/24 at 5:07 p.m., with LPN-A identified she sent the email to RN-A and the DON on 8/18/24 at 4:34 p.m On 8/16/24, when she saw R1's wound the wound bed appeared to be red in color but on 8/18/24, the wound bed now appeared to have white slough in the wound bed and an area that appeared to be brown in color, and another area at the 5 p.m. mark (like on a clock) that appeared to show muscle involvement in the wound. In her opinion, the wound had appeared worse as she recalled that was a change from 8/16/24, when she observed it and provided the dressing change. LPN-A had not documented her finding from wound care or dressing changes to identify characteristics of the wound, in order for staff to determine if changes were occurring that would warrant a more formal assessment or the need to update the physician. On 8/18/24 at 10:04 a.m., family member (FM)-A stated R1 was admitted to the facility with the wound on his tailbone area. FM-A stated R1 was sent to the hospital on 8/21/24 for another concern, and the non-visible wound was debrided surgically, and a wound VAC (vacuum) was placed. On 8/18/24 at 12:26 p.m., the medical director (MD) stated he would expect the facility to follow policy and procedures and if needed, notify him if a wound had deteriorated or showed signs and symptoms of infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/24 at 1:00 p.m., DON confirmed there was no documentation to support that assessments were documented, or a more thorough assessment had been performed. Review of facility policy titled Pressure Injury Management, dated April 2024, indicated a resident who had a pressure injury received necessary treatment and services to promote healing, prevent infection, and prevent the development of new pressure injuries. Upon performing dressing changes, staff were to have necessary supplies, practice goof infection control technique, inspect the wound, noting location and color, amount, and odor of any drainage or necrotic (dead tissue) debris. Staff were to note these characteristics, measure the wound, notify the physician for signs of infection or wound deterioration, and document the procedure.