STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245344	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Care Center	702 10th Avenue Northwest Dodge Center, MN 55927

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** 49616 Based on interview and record review the facility failed to comprehensively assess pressure ulcer (PU) development, implement appropriate interventions to prevent PU's and notify the provider of changes for 1 of 3 residents (R1) who entered the facility without pressure ulcers. This resulted in harm when R1 devleoped a stage 3 pressure ulcer. The facility implemented immediate corrective action, so the deficient practice was issued at past non-compliance. Findings include Definitions: Blister-a bubble of fluid under the skin. A pressure ulcer can develop into blisters and open sores, which can then become infected and grow deeper until they reach muscle, bone or joints. Stage 3 pressure ulcer is characterized by full thickness skin loss and may be deep. They affect the top two layers of skin and fatty tissue. Unstageable pressure ulcers develop from long-lasting pressure on the skin and means the full depth of the ulcer cannot be measured with slough or eschar obstructing the wound bed. R1's face sheet dated 2/20/25 identified R1 had diagnoses of fracture of right femur, there was no indication R1 had a current pressure ulcer. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 did not have cognitive impairment and was dependent on staff for all care areas. R1 did not have a pressure ulcer. R1's care plan dated 12/4/24, identified R1was at risk for skin breakdown. Interventions included follow facility protocol/regimen for treating breaks in skin integrity/pressure ulcers. Document all new abnormal skin findings. If skin is reddened, bruised, or has open areas, report to licensed staff. Skin mattress [pressure reducing mattress] on bed. Monitor skin with cares, showers, and as needed. (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 - Actual harm Residents Affected - Few	R1's progress note dated 12/17/24, identified a fluid filled blister that measured 2.0 cm x 0.5 cm on left upper thigh/buttock region. Believed to be from R1's personal wheelchair being too tight, with difficulty applying mechanical lift sling around R1. R1 received a new wheelchair. There was no indication the physician was notified of the impaired skin integrity. R1's occupational therapy notes with dates ranging from 12/4/24-1/23/25, identified on 12/18/24 R1 had a care conference and R1 had been transitioned from her personal 18 inch width wheelchair to a 22 inch width wheelchair. R1's progress note dated 12/21/24, identified R1's blister popped and a new dressing was applied. R1's record on 12/21/24 did not identify what type of dressing was applied nor did it include a comprehensive assessment that identified the wound was a pressure ulcer. Additionally, R1's care plan did not address the wound. R1's progress note dated 12/24/24, identified left upper thigh/buttock fold older blister now open. Wound bed moist, without noted bleeding and edges flaking. Measured 1.0 cm x 1.5 cm. Scant green drainage noted to old dressing, no odor. Continued with blanchable redness to peri-wound that measured 3.0 cm x 1.0 cm. Foam border applied. Clinical nurse manager updated. R1's a nursing order on 12/28/24 to monitor blister to left upper thigh/buttock fold until healed, every day and evening shift for blister. On 12/30/24, a nursing order for left upper leg blister directed: clean with normal saline and pat dry. Place silicone bordered foam dressing daily and discontinue when healed. R1's progress note dated 12/29/24, identified registered nurse (RN)-D assessed old blister site to left upper thigh. Area was open, moist, a mepilex in place with moderate amount of green drainage noted to the old dressing. No odor to wound. Base of wound had some slough noted along with some purple discoloration. No depth to wound. Wound edges irregular. Periwound red and blanchable. Area measured 1.0 cm x 0.5 cm. New mepilex placed. R1's progress note dated 12/31/24, the left thigh blister popped and measured 1.5 cm x 1.5 cm x 0.1 cm depth. R1's progress note dated 1/5/25, identified R1's dressing to left upper thigh was removed and was covered in 50% serosanguinous (thin, often slightly yellow, with a light pink tinge) drainage. R1's progress note dated 1/9/25, indicated the IDT reviewed R1's wound and noted there were not any concerns. No other information was identified. R1's progress note dated 1/13/25, identified R1 was seen by certified nurse practitioner (CNP)-A for a recertification visit. The note did not indicate the CNP was made aware of the wound at the time of the visit. R1's progress note dated 1/14/25, identified there was not a blister anymore, the area is an open wound that measured 3.5 cm x 4.0 cm x 0.5 cm depth. The wound bed is beefy red, with a small area of white and gray/black. No odor. Peri wound intact redness from moisture. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 1/16/25, identified no blister to the area anymore, the area is an open wound that measured 3.5 cm x 4.0 cm x 0.5 cm. The wound bed is beefy red, with a small area of white and gray/black. Peri wound intact redness from moisture. No odor at this time. R1's progress note dated 1/16/25, indicated the IDT reviewed R1's wound and noted there were not any concerns. No other information was identified. R1's progress note dated 1/22/25 at 7:10 a.m. identified a moderate amount of slough (dead cells, debris, and remnants of tissue that have not undergone proper breakdown and removal from the wound bed that can prevent or slow down healing) present to left upper thigh/buttock crease wound. R1's progress note dated 1/23/25, identified area is no longer a blister. It is an open wound that measured 3. 5 cm x 4.0 cm x 0.5 cm. Area is red with slough present. Mild odor noted. No complaints of pain at site. R1's physician discharge note dated 1/23/25, identified R1 had a pressure ulcer of left buttock that was unstageable. Reported to CNP-A today. Nursing had been treating with mepilex, and per report thought initially to be related to mechanical lift as blister had developed. Unstageable pressure ulcer at least a stage 3 as central portion of slough and eschar (dead tissue that develops on severe wounds usually stage 3 or 4 pressure injuries) present. Wound characteristics: full thickness pressure ulcer, unstageable but at least stage 3. Measured at 8.0 cm x 5.0 cm x unable to determine depth. Moderate exudate (drainage). Eschar/slough at center measured 3.0 cm x 1.8 cm. Irregular wound edges. Peri wound is blanchable. Tenderness with palpation at center of wound. Slight odor but no other symptoms or signs of infection. R1 was discharging to assisted living and additional orders for nursing services in relation to wound care was requested. Discussed with clinical manager consideration of a different method of mechanical lift transfer, changing from straps to a sling or other option that would reduce pressure applied during transfers. Wound care orders included: alternating pressure air mattress or pressure reducing mattress if air mattress unavailable, up to 30 degree turn side to side, head of bed when in bed; reposition every two hours or per tissue tolerance, reposition assistance or reminders to be provided on a regular basis based on patient condition, wheelchair or chair cushion per occupational therapy recommendations, elevate heels while in bed. Daily clean with vashe (wound cleanser made of pure hypochlorous acid to fight bacteria and infection) and rough gauze in circular motion, apply thin layer of medihoney to wound base, cover with silicone bordered dressing, closely monitor wounds, looking for signs and symptoms of infection. Contact provider if the patient develops: new wound or change in a wound, drainage from the wound increases, sudden increase in pain or new pain in the wound, area around the wound gets red, swollen, or painful to touch, wound color changes from pink or red to a tan, brown or black color, patient has a fever, or if the wound order gets worse. R1's progress note dated 1/23/25, identified R1 was seen by CNP-A for discharge and acknowledged the aforementioned orders given by the CNP. However, identified direction to reposition every hour. At 2:36 p.m., licensed practical nurse (LPN)-D notified assisted living registered nurse (ALRN) of the pressure ulcer and ALRN came to facility to assess. They are able to complete the wound care and can accept R1 1/24/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In review of R1's wound tracking/progress notes between 12/21/24 through 1/23/25, it was not evident the facility had appropriately staged the wound after the blister had ruptured and continued to deteriorate, not evident of assessment to determine appropriate care plan interventions to prevent the pressure ulcer from worsening and new ulcer development. Further not evident the physician was notified for appropriate treatment orders until 1/23/25. During a phone interview on 2/18/25 at 10:45 a.m., ALRN stated R1 had went to the nursing home for short term rehabilitation and was returning to assisted living facility when completed. ALRN went to facility on 12/30/24 to assess R1 for return. Facility reported to ALRN that R1 had been pinched by the mechanical lift shift on 12/29/24 and received a blister to the left upper thigh/buttock region. ALRN assessed the area and measured it at 1 centimeter (cm) x 1cm with a pinhole opening in the middle of it. ALRN received weekly updates from facility therapy department but was not informed of the wound worsening. ALRN went to the facility on [DATE] to assess the wound. Assessment included the wound measurement at 8cm x 5cm and was unstageable. ALRN stated they did an emergency readmission to their facility due to lack of care at the facility. During a phone interview on 2/19/25 at 9:39 a.m., family member (FM)-A stated the facility had not contacted him about the blister and the worsening of the wound on R1's left upper thigh/buttock area. During a phone interview on 2/19/25 at 3:52 p.m., licensed practical nurse (LPN)-B stated she did not notice the wound was bad and maybe she had been looking at the wrong spot. During a phone interview on 2/19/25 at 9:56 a.m., LPN-A stated R1's wound dressing was mainly completed on day shift. LPN-A recalled an agency staff member questioned the wound at one point during a shift and thought the wound was a stage 1-2 pressure ulcer. Any wound would have to be assessed, measured and the resident should have interventions that included repositioning off the area in question. other interventions could include an air mattress. Nurses usually reported changes in wounds to the nurse managers and then the nurse managers would notify the doctor. LPN-A stated the physician was not notified of the changes, The ball was dropped. During a phone interview on 2/19/25 at 10:48 a.m., LPN-C stated she first noticed the wound bed was beefy red with a small area of white and gray/black with no odor on 1/16/25. The next time she saw the wound there was green drainage on 1/23/25. The process for wound management was the floor staff put in a progress note about a wound and notify and/or update the clinical managers and ADON as needed. The clinical manager would notify the medical provider. The floor staff did not report to the physician. During an interview on 2/19/25 at 1:20 p.m., LPN-D stated she was aware of the blister on R1's left upper thigh. LPN-D stated she did not look at the wound and staff did not inform her that it had worsened. LPN-D was unsure how the communication breakdown occurred. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/19/25 at 8:10 a.m., RN-A stated wounds were measured weekly with the first showers. Residents with pressure ulcers would have more frequent repositioning. When a blister ruptured, the wound would be considered worse. The physician should be contacted when a blister opens. RN-A thought a different treatment should have been put in place for R1; having the wrong type of dressing could make the wound worse but would defer to the physician for appropriate treatments. RN-A explained he failed to notify R1's medical doctor or the nurse manager of the changes to R1's blistered area. RN-A should have notified the provider. RN-A explained the facility recently designated the ADON to lead the wound management program; ADON was the person completely weekly wound rounds. Prior wound changes would be reported to the nurse managers however did think the nurse managers were addressing the wounds because of time constraints. During an interview on 2/19/25 at 11:13 a.m., clinical nurse manager RN-B reviewed R1's record and explained on 12/17/24, the IDT reviewed the presence of the new blister which was determined to be a result of R1's personal wheelchair being tight, and friction/shearing occurred while placing the mechanical lift sling under her. The facility got R1 a better fitting wheelchair and IDT determined a mepilex placed over the blister for treatment. The provider was not notified by RN-B or LPN-D. Then on 12/21/24 the blister opened but RN-B and LPN-D were not notified until 12/24/25. The physician again should have been notified, however, was not. 12/29/25, RN-B completed the dressing change to R1 and noted green drainage, slough tissue, purple discoloration, and the wound had irregular borders. The wound had changed significantly since RN-B had seen it. The physician was not notified, and the orders were not changed. On 1/13/25, when the wound measured 3.5cm x 4.0cm x 0.5cm depth, certified nurse practitioner (CNP)-A was at the facility and had an appointment with R1. CNP-A did not review the wound and did not have knowledge of the wound at this time. R1's care plan had not been revised to reflect the wound; care plans should be updated when a new issue is discovered with new interventions to prevent the wound from worsening such as air mattress, repositioning schedule, and diet changes. RN-B indicated there had been a breakdown in communication, however, the facility has a different process in place and one person, ADON, designated for wound management. ADON completes the weekly wound rounds. New skin issues were now reported on a communication board or in the risk management tab, which was new to the facility and communicate any concerns to herself, ADON, or LPN-D. Between wound rounds nurses were expected to complete the dressing change as ordered, assess the wound, document findings, and immediately notify if any changes. During a phone interview on 2/19/25 at 9:56 a.m., R1's CNP-A stated she came to facility to complete R1's discharge paperwork on 1/23/25. CNP-A was told R1 had a blister on her left upper thigh/buttock region and looked at it. CNP-A stated she was quite surprised by what she saw. The area measured 8cm x 5cm with an undetermined depth that she would stage at least at a stage 3 or more and the wound required some debridement (removal of dead or infected tissue from a wound to promote healing). CNP-A expected to be notified when the wound occurred. CNP-A would have prescribed something more than just a mepilex (foam dressing) to cover the wound. The facility did not explain why she was not informed of the wound. Left untreated the wound could have certainly worsened and could lead to an infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/19/25 at 11:41 a.m., ADON stated she had taken over wound care very recently. ADON would expect the physicians to be notified of wounds and of wound changes. On 12/29/24, R1's blistered area would be considered a pressure ulcer, and the physician should have been notified. ADON was unsure why the first notification to the physician occurred on 1/23/25 and not prior. There has been a lot of revamping to the wound program at the facility since she took over the wounds. ADON has been completing 1:1 wound care with floor nurses, education on wound documentation, how to assess a wound, how to properly measure a wound, and auditing the floor staff with wound rounds weekly the last few weeks. Education with floor staff was also completed by an outside agency for wound care on 2/11/25. ADON had implemented a flow sheet that is sent weekly to the nurse managers, DON, MDS coordinator, nurse practitioner, wound supplier, hospice, and dietary manager that included. The flow sheet included resident identifier, who provides wound supplies, where the wound was located, what the wound measurements are, date identified, current treatments, current interventions in place, brief assessment in the comments of what is going on with the wound, along with color coding the measurements green if it is smaller and red if it is changing. The ADON stated, wounds have gotten a lot better and communication and documentation have come together. Floor staff were comprehending and understanding what was needed from them with all the recent and continuing education on wound care. During an interview on 2/19/25 at 1:31 p.m., DON stated R1's wound was initially a minor blister and the medical provider would not need to be notified. As the wound progressed the physician should have been notified. The area should have been care planned and proper interventions put into place. DON stated wound care had been an issue that was recognized as a problem and the facility had been working on correcting it. The following corrective actions were verfied as implemented prior to the survey: On 1/8/25, ADON implemented weekly wound rounds with nursing staff providing 1:1 education and started an auditing system for wound monitoring and documenation. The facility reviewed and revised the wound managment policy and protocals on 1/22/25. The afternoon of 1/22/25, education was provided to staff pertaining to wound monitoring, documentation, physician notification, communication, and comprehensive assessments. R1's record was reviewed by the CNP which resulted in appropriate treatments and interventions were developed and implemented on 1/23/25. R1 was discharged from the facility on 1/24/25. Sampled resident records were reviewed from 1/23/25 through 2/19/25 did not identify deficient practices pertaining to pressure ulcer management. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility Skin Issues and Wounds policy dated 2/13/23, identified body audits are completed within 24 hours of admission and on shower days. Evaluation of risk factors and Braden scale is done on admission and once per week x 4 weeks and then quarterly or with any new pressure injuries. Tissue tolerance evaluation is done within the first 24 hours of admission and an individualized repositioning program is devised and re-evaluated annually and as needed. When a skin issue is noted licensed staff fill out an incident report or ulcer of unknown origin report, each clinical nurse manager is notified of the skin issue. Wound rounds are done by designated nurse or clinical nurse manager. The are is measured and using nursing judgement, staff initiate appropriate treatment. Medical doctor notified if needed. IDT to review skin issues as needed. Progress notes from IDT are written weekly. The facility Pressure Ulcers/Vascular Ulcers policy dated 1/25, identified pressure ulcers/vascular ulcers will be evaluated weekly by an RN delegated to wound rounds. Weekly documentation by RN will include: measurement of length, width, and depth of wound, odor, drainage including color and amount, skin temperature and color, appearance of wound bed, current treatment including supplements. When an ulcer/pressure area is noted, licensed staff fill out an incident report/risk management and the RN is notified of the skin issue. Staff initiate appropriate treatment and medical providers notified as needed. Medical providers will review all skin conditions on rounds. IDT review new skin conditions at morning meeting. When pressure ulcers have resolved, area will be monitored by RN for two additional weeks. If area remains clear, tissue tolerance will be evaluated to determine repositioning schedule. The facility Care Plan policy dated 12/15/23, identified facility will develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a residents medical, nursing, mental and psychosocial needs. The care plan will reflect intermediate steps for each outcome objective if identification of those steps will enhance the residents ability to meet objectives. The care is evaluated and revised as the residents status changes. The care plan is oriented toward preventing avoidable declines in functioning and functional levels, attempts to manage risk factors, build on resident strengths, and reflects standards of current professional practice.