

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245399	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/26/2024
NAME OF PROVIDER OR SUPPLIER Little Falls Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 First Avenue Northeast Little Falls, MN 56345	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47790</p> <p>Based on observation, interview, and document review, the facility failed to follow physician orders for pressure ulcer care, and failed to follow infection control practices during a dressing change for 1 of 3 residents (R1) reviewed for pressure ulcers.</p> <p>Findings include:</p> <p>Definitions of pressure ulcer types according to National Pressure Ulcer Advisory Panel (NPUAP):</p> <p>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 that 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 the 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, it is an unstageable pressure ulcer.</p> <p>Stage 4 Pressure Ulcer: Sores that extend below the subcutaneous fat in deep tissues including muscle, tendons, ligaments, cartilage, or bone. This stage presents a high risk of infection.</p> <p>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.</p> <p>R1's Face Sheet dated 7/25/24 indicated R1 had diagnoses of peripheral vascular disease, quadriplegia, and spinal stenosis.</p> <p>R1's significant change Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact and fully dependent on staff for activities of daily living (ADLs). R1's quarterly MDS dated [DATE] indicated R1 had one Stage 4 pressure ulcer.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's Integrated Wound Care document dated 7/23/24, indicated a Stage 4 sacral pressure ulcer measuring 6.5 centimeters (cm) by 12.5cm and 1.8cm in depth, undermining (destruction of tissue extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface.) from 11 to 3 o'clock was 4.1cm in depth. The Stage 4 sacral pressure ulcer had heavy purulent drainage (product of inflammation that contains pus), mild odor, bone exposed, had 90% granulated (connective tissue) and 10% slough (non-viable yellow, tan, gray, green or brown tissue) on wound base. The document indicated an unstageable left buttock pressure ulcer measuring 9cm by 8cm and 3cm in depth, undermining from 12 to 3 o'clock was 5cm in depth. The unstageable left buttock pressure ulcer had heavy serosanguinous (a mixture of clear serous fluid and blood), tendon and bone exposed, had 10% necrotic (dead tissue) and 50% slough on wound base. The document indicated a Stage 3 right buttock pressure ulcer measuring 6.3cm by 4.5cm and 1.2cm in depth, undermining from 10 to 4 o'clock was 4.5cm in depth. The stage 3 right buttock ulcer had heavy serosanguinous drainage, 50% slough, 10% granulation, and 40% necrotic tissue on wound bed. The document had a note section that indicated a discussion was had with R1 about the continuous wound deterioration, and the likely outcome of continued wound deterioration.</p> <p>R1's Wound Care Order as ordered by the nurse practitioner (NP)-A on 7/23/24 directed for sacral and left buttock pressure ulcer: cleanse wound, apply skin prep to peri wound, cover bone with Adaptic (non-adhering wound dressing), then apply Santyl (ointment that removes dead tissue from wound) to wound bed, then calcium alginate (non-woven, absorbent dressing made from seaweed). May fluff kerlix to fill depth of wound, into fissure, and undermining areas if needed. Cover with abdominal pad dressing (ABD) and tape, change daily and as needed (PRN). Right buttock pressure ulcer: cleanse wound, apply skin prep to peri wound, apply Santyl to wound bed and calcium alginate, cover with silicone boarder dressing, change daily and PRN. R1's electronic health record (EHR) indicated both orders started on 7/25/24.</p> <p>On 7/25/24 at 10:24 a.m., registered nurse (RN)-A was observed providing wound care to R1. RN-A donned proper personal protective equipment (PPE). RN-A cleansed all three pressure ulcer beds with wound cleanser, then removed her soiled gloves. Without performing hand hygiene, RN-A donned clean gloves. RN-A placed Adaptic on the base of the left buttock and sacral pressure area where bone was exposed. RN-A placed calcium alginate on all three wound beds with a cotton swab. RN-A took the cotton swab and packed R1's left buttock ulcer with kerlix. RN-A grabbed new kerlix and packed R1's sacral ulcer. RN-A applied ABD dressings to all three pressure ulcers and secured bandages with tape. RN-A removed her soiled gloves, and without performing hand hygiene, donned clean gloves. RN-A placed another piece of tape on R1's left buttock dressing. RN-A removed her spoiled gloves, and without performing hand hygiene, removed R1's oxygen tubing from his nose. RN-A doffed her PPE and preformed hand hygiene before exiting the room. RN-A did not put Santyl on the wound beds as ordered.</p> <p>On 7/25/24 at 10:51 a.m., RN-A stated it slipped her mind to perform hand hygiene between glove changes, but the expectation was to sanitize hands after removing soiled gloves.</p> <p>On 7/25/24 at 1:13 p.m., RN-A stated she did not follow the physician's orders for R1's dressing changes because she was nervous.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/25/24 at 2:57 p.m., nurse practitioner (NP)-A stated R1's ulcers were going to happen due to R1 comorbidities and refusals to offload. If the facility was not following the physician's orders for pressure ulcer care, the integrity of the pressure ulcer is going to be compromised. She would expect the facility to follow orders. Hand hygiene and protecting the wound from unwanted bacteria was also important to healing when completing a dressing change.</p> <p>On 7/26/24 at 11:34 a.m., the administrator stated staff should follow care plans, orders, and to follow the hand hygiene policy.</p> <p>The facility policy Hand Hygiene revised 5/8/17, indicated hand hygiene is to be completed before and after direct contact with a resident, if moving from a contaminated body site to a clean body site during resident care, and between glove changes.</p> <p>A policy on pressure ulcers was requested but not provided.</p>