STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245449	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Crispin Living Community	213 Pioneer Road Red Wing, MN 55066

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338 Based on interview and document review, the facility failed to assess, monitor and treat a surgical wound according to physician orders for 1 of 1 resident (R1). This resulted in immediate jeopardy (IJ) when the wound dehisced and became infected resulting in a five-day hospital admission with surgical intervention, antibiotic therapy, and wound vacuum assisted closure (VAC). The immediate jeopardy began on [DATE] when R1 admitted to the facility and the facility failed to comprehensively assess the surgical wound and transcribe physician's orders for its monitoring and treatment, and was identified on [DATE]. The administrator and director of nursing were notified of the immediate jeopardy on [DATE] at 4:53 p.m. The immediate jeopardy was removed on [DATE] at 5:17 p.m., but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 admitted to the facility on [DATE] from a hospital with diagnoses including multiple fractures of pelvis with stable disruption of pelvic ring (multiple pelvic fractures where the broken bones remain in a stable position), other fracture of right femur, hip fracture, contusion (bruise) of right thigh, and complication of unspecified artery following a procedure. The MDS indicated R1 was cognitively intact, had an indwelling catheter and was occasionally incontinent of bowel, had a recent fall with fracture and recent major surgery, had surgical wound(s) and surgical wound care, and was 73 inches tall and weighed 252 pounds. R1's hospital After Visit Summary (Facility) document dated [DATE], indicated R1 was discharged from the hospital and the Lines/Drains/Airways/Wounds list included Wound [DATE] Incision Groin Left. Discharge Wound/Incision Care Instructions were included for a hematoma/contusion (collection of blood trapped outside of a blood vessel), but the document did not include instructions regarding the left groin incision. (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: 245449	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's hospital Discharge Summary document dated [DATE], indicated R1 discharged from the hospital on [DATE] and included a section titled VASCULAR SURGERY RECOMMENDATIONS with subheading Mepilex Ag Dressing [an antimicrobial foam adherent dressing]. The provider recommendations were 1. You had a special dressing placed over your left groin incision on [DATE]. This is to aid in wound healing and prevent wound breakdown where the skin surface causes friction. 2. You may shower with this dressing in place. 3. If three of the dressing edges are saturated with drainage, please immediately remove the dressing. 4. This dressing will stay in place for seven days. Remove your dressing on [DATE]. 5. If you note that there is redness or drainage around the incision, please call [doctor's] advanced practice provider through the [hospital's] operator [phone number]. 6. After removing the dressing, keep the groin area clean and dry. The following section was titled VASCULAR RECOMMENDATIONS and included In ,d+[DATE] days, our team would like to see him either in [clinic] or here in hospital to assess the groin incision and drain (appointment created). The outpatient follow-up appointments list included an appointment with vascular scheduled for [DATE]. The details of hospital stay narrative section indicated a diagnosis of femoral pseudoaneurysm (outpouching of the wall of the femoral artery due to injury with leaking blood that collects in surrounding tissue) post procedural complication and identified R1 had a hematoma associated with his left femoral artery that was removed, a drain (Jackson Pratt surgical drain, JP drain) was placed into the site of the hematoma, the femoral artery was repaired with sutures, and a wound VAC was placed over the wound that was later removed though the drain and sutured site remained with a plan for later removal of the drain. In review of R1's electronic health record (EHR), the treatment orders for R1's left groin incision from vascular surgery included on the Discharge Summary dated [DATE], were not present. The treatment orders were not transcribed into R1's physician orders, were not present on the Medication Administration Record (MAR) or Treatment Administration Record (TAR), and were not included in the baseline care plan. Review of R1's EHR did not identify any documentation noting the presence, absence, or removal of the Mepilex Ag dressing ordered to be in place over the left groin incision through [DATE]. R1's physician order dated [DATE], instructed staff to-complete full admission skin assessment utilizing skin check sheet, with 2 nurses signing; remove all NON-SURGICAL dressing to observe skin; turn into care manager (CM) when complete scheduled for completion one time between 2:30 p.m. and 10:00 p.m. on [DATE]. R1's TAR included the order charted as not administered: other on [DATE] at 11:39 p.m. R1's physician order dated [DATE], instructed staff to complete Weekly Bath/Skin Note (similar to admission note), VS [vital signs], weight, observe for new skin issues, include grooming performed, shaving, nail care, transferring assist to/from shower/bath, amount of assistance needed. Document refusals and approaches used schedule for completion once daily on Mondays with start date of [DATE]. R1's baseline care plan for skin with creation date of [DATE], noted I am at risk for alteration of skin status d/t [due to] assist with adls [activities of daily living] and mobility. Goals included I will not have further skin alteration related to _____ (describe current skin breakdown or wound). Interventions included I require a wound treatment plan as follows: ______ (describe steps). The skin care plan contained blanks and was not completed or individualized for R1, it did not identify his current alterations in skin integrity. A Skin Risk Observation with Braden Scale assessment dated [DATE], identified R1 had a surgical wound however the location and description was not included. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Clinical Documentation (Admission) assessment dated [DATE], included Skin Assessment with Braden Score: . indwelling catheter that is draining dark yellow clear urine at time of assessment. Ketoconazole [anti-fungal] cream applied to groin and folds and Polysporin applied to scrotum and penis daily for redness and has swelling to scrotum with scrotum sling in use . Skin is observed by CNA with cares and assessed weekly by licensed nurse. Goal is to remain free from pressure related skin impairments through next review date. No referrals or change of action needed at this time. Will continue with POC and update Provider with any changes as needed. It did not identify R1's left groin incision. R1's progress notes dated [DATE] at 5:50 a.m., identified presence of the JP drain, progress note at 1:56 p. m. identified R1 had skin care and treatments, which were not defined, and progress note at 9:58 p.m. indicated skin care and treatments were completed to R1's scrotum. None of the three progress notes identified the presence of the left groin incision. R1's progress notes dated [DATE] at 6:19 a.m. identified R1's catheter and JP drain and progress note at 2:54 p.m. indicated R1 had skin care and treatments, however neither progress notes identified the left groin incision. A progress note dated [DATE] at 9:39 p.m., identified antibiotic ointment was applied to the scrotum and penis, noted the presence of the catheter, and indicated abdominal and groin folds had been cleansed and patted dry with no redness or foul odor noted. Progress notes dated [DATE] did not identify the presence of R1's left groin incision. R1's progress notes dated [DATE] at 6:15 a.m. and 4:28 p.m. identified R1's JP drain however, did not mention R1's left groin incision. A progress note dated [DATE] at 9:11 p.m., indicated R1 received a bed bath and included observe for new skin issues: no new issues observed. Continues to have multiple old bruises on right forearm, right hip and leg, swollen scrotum which is treated with polysporin [antibiotic ointment] this eve[ening] per md [doctor] orders. Abdominal folds and groin have slight redness no foul odor or tenderness. Cleansed patted dry and anti-fungal applied per md[doctor] order. It did not identify R1's left groin incision. A paper skin observation charting form dated [DATE], indicated it was completed with R1's bed bath on the p. m. shift. It included an outline of a person with a circle around the left hip and L[left] side large bruise. It contained no further assessment of the bruise such as size, color, or pain and did not note R1's left groin incision. A second paper skin observation charting form dated [DATE], included a depiction of the front of a body with a circle around the outer edge of the right forearm and note scattered bruises, a circle around the outer right hip with note bruise, circles around the lower abdomen and left groin with note faint redness. The depiction of the back of the body included a circle around the outer right forearm with note scattered bruises, circle around the peri-area with note swollen scrotum, and circle around the outer right hip with note bruising. No further assessment of the noted bruises, redness, or swelling was included and it did not note R1's left groin incision. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's baseline care plan for infection with creation date of [DATE], noted I require Enhanced Barrier Precautions r/t [related to] presence of indwelling catheter, JP drain, and surgical incision. Goals included I will not develop signs or symptoms of infection. Interventions included monitor for signs and symptoms of infection, and notify physician/nurse practitioner if signs and symptoms occur. R1's record that included progress notes dated [DATE], [DATE], and [DATE] mentioned R1's JP drain however did not identify the presence of R1's left groin incision. A progress note dated [DATE] at 3:20 p.m., identified R1 was seen by the primary care provider Physician Assistant, had a clinic appointment the next day, and noted the presence of the JP drain. It did not identify R1's left groin incision. A Physician Assistant visit note dated [DATE], indicated R1 had an appointment with vascular surgery the next day but did not include identification or assessment of R1's left groin incision. A progress note by the director of nursing (DON) dated [DATE] at 12:38 p.m., included Resident went out to his follow-up ortho[pedics] appointment today where it was found that his left groin incision had dehisced. He was admitted for surgical management, left groin irrigation, and debridement. He will remain in the hospital throughout the weekend. A vascular surgery office visit note by nurse practitioner (NP)-A dated [DATE], indicated R1 was seen in the clinic for wound assessment. It included [R1] presents today with no information from his nursing facility . He believes the facility removed the Mepilex from his left groin incision a few days ago. They have not been utilizing any gauze to his groin incision . Left groin incision: wound dehiscence to the very center aspect of the incision, approximately 1.5 cm . [R1] unfortunately has experience [sic] dehiscence of his left groin incision. Admit to [physician's] surgical service and proceed to operating room for left groin irrigation and debridement. A hospital Surgeon Documentation note dated [DATE], indicated R1 was known by the surgical service from his previous surgery for evacuation of a large left-sided groin hematoma and primary repair of his actively bleeding femoral artery. It noted He was seen in clinic today for evaluation of his wound and was found to have some dehiscence with opening of the skin around his nylon sutures. For this reason he was brought to the operating room for irrigation and debridement [removal of infected or diseased tissue in a wound and washing out the open wound] . Upon initial inspection of the wound it was clear that he had had dehiscence in the medical portion of the suture line but has [sic] other sutures remained intact . we sharply debrided [cut away] a 3 x 3 x 3 cm [centimeter] area of necrotic fat The decision was made to place a wound VAC for ongoing drainage . we will plan to bring him back to the operating room on Monday for another irrigation and debridement. A hospital Infectious Disease physician consult note dated [DATE], identified bacterial culture swabs from R1's left groin site returned positive for two types of bacteria, enterococcus faecalis and citrobacter koseri. The recommendations included continuing the intravenous antibiotics R1 was already receiving and, upon discharge, to complete a further course of oral antibiotics for two weeks after the date of his last debridement. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospital Discharge Summary dated [DATE], noted R1 was admitted on [DATE] and discharged on [DATE]. Follow-up noted wound vac is to continue until you are re-evaluated by a member of [doctor's] surgical team, and will most likely continue for many weeks, possibly up to a few months. The Details of Hospital Stay, noted R1 was directly admitted from [clinic] on [DATE] for management of left groin wound dehiscence. He proceeded to the operating room on [DATE] and underwent left groin irrigation and debridement with wound VAC placement . He proceeded to the operating room again on [DATE] and underwent left groin irrigation and debridement. Left groin incision with wound vac in place. In an interview on [DATE] at 12:30 p.m., hospital vascular nurse practitioner (NP)-A stated she had previously cared for R1 when his left femoral artery required nylon sutures and indicated he discharged from the hospital on [DATE] with nylon sutures that were very nicely closed and no issues whatsoever with any openings and a Mepilex Ag dressing that was to stay on for seven days. NP-A stated she saw R1 at a vascular surgery clinic appointment on [DATE] and the Mepilex was off and his groin incision was very obviously dehisced. She states we should have been called or talked to about it and that required him to be readmitted and needing a couple of wash-outs of that groin and now wound VAC placement. The cultures from that came back positive for enterococcus requiring him to be on antibiotics. NP-A stated R1 reported no one even looked at his groin while he was at the facility and NP-A noted R1 was a larger guy and it would require lifting up his pannus to visualize the groin area where the incision was located. She stated that, upon inspection at the appointment, the groin incision was approximately six inches and had dehisced in the center of the incision probably two centimeters wide and at minimum a centimeter and a half deep. She stated R1 also had a JP drain on the left side, but it was approximately four to six inches away from the incision. NP-A stated possible outcomes of the dehiscence were repeat surgical intervention, overall infection risk, he could have gone septic from this, I think that would be the worst outcome from this if it were to have gotten any worse, or if it got down to the artery and if the artery was exposed he could have bled to death. NP-A stated I would say that it [the dehiscence] was probably happening over a minimum of three days. Regarding treatment, NP-A noted the expectation from the vascular surgery group was that if the Mepilex Ag dressing had stayed intact it would be removed at the seven day mark ([DATE]) and gauze would be placed in the area to avoid any moisture or skin-on-skin contact to prevent breakdown, and even though the discharge instructions did not say specifically to use gauze they instructed staff to keep the area clean and dry. In an interview on [DATE] at 9:33 a.m., R1 stated facility staff didn't pay attention to that groin area incision that I had when I went there. I just had a couple of stitches in the groin . I went with the stitches and a little drainage bag [JP drain], they drained the bag but they never checked the groin where the incision was, it was on the left side. R1 stated staff never checked on the incision or cleaned around the incision. He did not recall having a dressing on it and stated there was no dressing, one of them looked at it and said I don't know why there isn't gauze there but they didn't pay attention to that. R1 stated he wasn't able to visualize the incision because of its location and he thought everything was going well with it until his appointment with vascular surgery and noted bacteria was found in the incision so I imagine it must have been open for more than one day. He stated he was admitted right away after his appointment and then I had surgery again, I think I was put under two or three times and now I have a wound VAC on that area where the incision is which is another thing I have to deal with, another machine on me . It has delayed everything and not only do I still not have my weight bearing on that leg now I also have the wound VAC to deal with and physical therapy is limited as to what they can do with me. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 8:08 a.m., licensed practical nurse (LPN)-A stated she remembered R1 wasn't there long, but he was a big guy with a drain and a catheter. LPN-A stated he had an incision, a surgical incision, I don't remember where it was LPN-A stated I don't remember documenting his incision site and I didn't remember an order in there to do anything with it and noted this was an oversight because they should have had an order. LPN-A stated R1 arrived at the facility during her shift, but second shift usually completed skin check and confirmed she would include surgical incisions and bruises on a skin assessment. LPN-A stated with a surgical incision with no orders she would contact the clinical manager and assumed they were to leave it alone, but if it was wet and nasty she would call the provider to get an order to do something. In an interview on [DATE] at 1:26 p.m., LPN-B stated she remembered R1 and had taken care of him for a few days. She noted R1's groin area had been bruised and she thought he had an angiogram in the hospital where they nicked an artery and he had a bleed in the groin area, but did not recall an incision or dressing in his groin. In an interview on [DATE] at 1:54 p.m., registered nurse (RN)-C stated R1 had a femoral dressing in his groin from something post-operative and thought it was on the left, but honestly I can't recall if I ever saw it. RN-C did not identify a dressing present on the left grin incision. In an interview on [DATE] at 8:55 a.m., RN-B stated she was covering for clinical manage (CM)-A when R1 admitted and completed his admission assessments though she did not provide direct care for him. RN-B stated he has an incision, can't remember which side, it was in his hip and he had a JP drain out of a separate spot on his left side and stated she had never seen the incision. RN-B stated she was aware R1 had orders for wound care but did not recall the details of the wound care orders. She stated if someone had a surgical incision and a dressing and no orders she would call to get orders and check with her manager. RN-B noted she would look at orders to see how to manage a specific wound because hospital discharge orders usually specify what you have to do. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:06 a.m., CM-A stated she was not familiar with R1 as did not work during the time of his admission. CM-A confirmed R1's admission skin assessment, Skin Observation Form dated [DATE], should have been completed on [DATE], noted a need for surgical wound care but did not identify the wound, did not identify the left groin surgical incision, did not note the JP drain site, did not meet her expectations for assessment of bruises, and did not constitute a comprehensive skin assessment. CM-A confirmed R1's EHR did not include orders for monitoring or treatment of the left groin surgical incision, progress notes did not include documentation of monitoring, there was no documentation of a dressing over the left groin surgical incision, no documentation that wound care for the surgical incision was provided per provider orders, and stated I don't see the assessment or monitoring of the surgical incision in the groin anywhere. She further confirmed R1's baseline care plan was not completed and did not identify his left groin surgical incision or the treatment plan, stated it should have been included in the care plan, and noted the baseline care plan should have been completed per protocol within 48 hours of admission. CM-A noted wound care orders for the left groin surgical incision were included in the hospital's Discharge Summary but not the After Visit Summary and the facility utilized the After Visit Summary for admission orders, not the Discharge Summary, but she was aware the hospital sometimes has other orders in the Discharge Summary that are not included in the After Visit Summary. She confirmed that if R1 had a surgical incision but did not have wound care orders she would expect nursing staff to notice something was missing and obtain orders by reaching out to her or the on-call provider. CM-A stated I have no idea what happened, I was gone and it fell through the cracks. It appears a couple checks didn't happen. She identified potential outcomes of the lack of assessment, monitoring, and treatment as infection, sepsis, and he could have died if we're going for worst case scenario. In an interview on [DATE] at 12:41 p.m., the DON stated R1 had had admitted to the facility with the left groin surgical incision and at a follow-up provider appointment on [DATE] they noted the incision had dehisced and he was admitted for further care of his incision. The DON confirmed she was aware there were discrepancies between the orders in R1's hospital Discharge Summary and After Visit Summary. She confirmed R1's EHR lacked documentation of assessments of the incision and stated there was no comprehensive assessment. The DON noted she would expect the incision to have been assessed within eight hours of admission, to be monitored every shift, findings to be documented, and the provider to be updated with any concerns or abnormalities noted. The DON stated she would expect the incision's dressing to be put in as an order and to have been documented. She noted the assessment and monitoring of R1's bruises were not in line with her expectations for monitoring every shift and weekly comprehensive skin assessments. The DON stated she could not demonstrate that R1's left groin surgical incision was treated in accordance with physician orders or assessed and monitored in accordance with physician orders and facility policy. She identified potential outcomes as adverse events, infection, many terrible things. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 1:59 p.m., the facility's medical director (MD) stated he had spoken to the DON about R1 and knew a bit about the situation. The MD stated he would expect staff to identify the presence of a dressing, wound, incision, or skin or soft tissue abnormality through orders from the hospital to monitor and care for it, in the discharge summary if it wasn't in the orders, or from the initial body audit (comprehensive skin assessment on admission) completed same day or by the morning after admission. He would expect treatment and monitoring per physician orders and if there were no orders, would expect staff to talk to the attending provider or hospital provider to make sure they didn't omit orders and, if they did, find out what needs to be done in terms of monitoring and dressing changes. The MD identified possible outcomes of the femoral groin incision not being monitored, assessed, and treated as a potential delay in observing a change in condition of the groin, superficial or deeper infection, wound dehiscence, aneurysm or pseudoaneurysm, or other potential vascular complications. The MD stated, it is more of a delay in identification if it [the incision] dehisced before the person [R1] was at the office visit, and noted we know there was a delay in identifying anything that might have been doing on but when it exactly was going on was unclear. The MD stated, treatment should be provided in accordance with orders so you can identify changes in condition when they occur more promptly and to carry out what a specialist wants in terms of particular wounds. The MD confirmed the incision was seemingly not tended to and noted the facility lacked a plan of care for the incision. Facility policy titled Prevention and Treatment of Skin Breakdown dated [DATE], included Resident skin integrity is assessed upon admission and weekly thereafter . 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 . A licensed nurse completes Braden Skin Risk Assessment: Upon admission or readmission; Weekly for the first 4 weeks post admission or readmission . A resident centered care plan is implemented/updated for skin risk with interventions based upon; Areas of risk; Resident Assessment; Braden evaluation score of 15 or less; Clinicians assessment/evaluation; Resident preferences. Members of the care team are notified and consulted as necessary. Skin integrity is monitored and abnormal findings are documented: Skin is observed daily with cares. If any skin concerns are noted, they are reported to the licensed nurse; Weekly skin audits are performed by a licensed nurse. Facility policy titled Comprehensive Assessments and Care Planning dated [DATE], included A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals, and sign and certify that the assessment is completed. The assessment process begins with the development of the baseline care plan within the first 48 hours of admission. The baseline care plant includes the minimum healthcare information necessary to care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury. Baseline care plans address, at a minimum, the following: Initial goals based on admission orders; Physician orders . The baseline care plan reflects the resident's stated goals and objectives, and includes interventions that address his or her current needs . The assessment must accurately reflect the resident's status, and each person who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment . The following assessments and time frames are calculated from the day of admission unless otherwise noted . Baseline Care Plan developed with 48 hours of admission . skin assessment within 8 hours. Facility policy titled Order Review dated ,d+[DATE] included Purpose: To assure appropriate medications and treatments are in place for each resident. Procedure: EHR System: Orders are transcribed into the electronic health record. (continued on next page)

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