STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245537	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnewaska Community Health Services	605 Main Street Starbuck, MN 56381

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** Based on interview and document review, the facility failed to implement daily monitoring and assessment of a deep tissue injury (a type of pressure ulcer, a serious condition that affects the underlying layers of skin, muscle and other soft tissues) for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment and diagnoses which included: diabetes mellitus, cerebral vascular accident (stroke) and anxiety. R1 required partial/moderate assistance with toilet use, hygiene, and substantial/maximal assistance with dressing and transfers. R1 was at risk for pressure ulcers and had no unhealed pressure ulcers. R1's Pressure Ulcer Care Area Assessment (CAA) dated 6/5/25, identified R1 was at risk for potential pressure ulcers and R1's skin was assessed each week by a nurse, and by caregivers with each bath and each time R1 was dressed. Identified interventions were in place to prevent skin break down. R1 would be assisted with repositioning at least every two hours and as needed for comfort. R1's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation dated 6/11/25, identified R1 had a score of 14, which identified R1 was at moderate risk for pressure ulcers. R1's Weekly Wound Round Documentation dated 6/20/25 at 11:21 a.m., identified R1 had a pressure wound acquired 6/20/25. The pressure wound was located on R1's sacrum (area at base of the spine) with length of 6 centimeters (cm), 4 cm width, no depth, and staged as a suspected deep tissue injury. The assessment identified no drainage and surrounding tissue was intact. Current treatment plan was moisture barrier, mattress air overlay and wheelchair/Broda chair (large adjustable cushioned wheel chair) cushion. The assessment identified no pain or odor. R1's care plan revised 6/23/25, identified R1 had a potential for activities of daily living (ADL) self-care performance deficit with interventions which included assistance of one with bathing, bed mobility, dressing, and grooming. R1's care plan identified R1 had limited physical mobility and required Hoyer (mechanical lift) for all transfers. R1 had actual impairment to skin integrity related to mechanical forces, impaired physical mobility, knowledge deficit and impaired circulation/perfusion, as evidenced by (AEB) tissue damage, changes in appearance of the affected area. Interventions included mattress air overlay, required (pressure relieving/reducing mattress, pillows, sheepskin padding etc) to protect the skin while in chair/wheelchair or bed, and weekly documentation. (continued on next page)

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	R1's progress notes reviewed 6/1/25 to 7/1/25, identified the following: -6/20/25, at 10:55 a.m., skilled evaluation: R1's skin: 1. The note identified the number one and lacked any further documentation. -6/21/25 at 1:10 a.m., skilled evaluation: R1's skin warm and dry, skin color WNL and turgor is normal. -6/21/25 at 11:33 a.m., skilled evaluation: R1's skin warm and dry, skin color WNL and turgor is normal. Skin issue # 001-identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present. Painful yes, no measurements documented as part of the assessment, with reason as not applicable (n/a). -6/22/25 at 6:00 a.m. skilled evaluation: R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present -6/22/25 at 2:06 p.m., skilled evaluation: R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present -6/22/25 at 6:49 p.m., skin check: delegated to night nurse. -6/22/25 at 10:56 p.m., skilled evaluation: -R1's skin issue #001- had not been evaluated. -identified as: new skin issue, sacrum, type, bruising, unknown how long the wound had been present. -6/23/25 at 12:02 p.m. R1 sent to emergency room due to change in level of cognition (LOC) and required oxygen to keep sats over 88%. R1's medical record lacked documentation of daily monitoring of R1's pressure ulcer, including: if pain present, location, staging, size, drainage, description of wound bed, wound edges and surrounding tissue. Review of R1's emergency room attending physician's progress notes dated 6/23/25, identified a severe decubitus ulcer, sacral region unspecified stage. During interview on 6/30/25 at 2:03 p.m., nursing assistant (NA)-A stated NA-A had notified the nurse, case manager and director of nursing (DON) on 6/20/25, that R1 had a dark bruise area on her sacral area, and DON assessed it. During interview on 7/1/25 at 8:16 a.m., registered nurse (RN)-A stated RN-A had become aware of R1's deep tissue injury on 6/20/25, and notified DON. RN-A confirmed she had sent R1 to the emergency room on 6/23/25, and had not observed or assessed R1's pressure ulcer. RN-A said her usual practice for when to monitor pressure ulcers, was when completing dressing changes, or to check to assure the dressings were intact. RN-A stated DON completed all other wound assessments weekly as the wound nurse. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/1/25 at 8:45 a.m., DON stated she was the facility wound nurse. DON confirmed she had been informed by the nursing staff on 6/20/25, that R1 had an darkened area on sacrum. DON reviewed R1's progress notes with skin assessments, and indicated she was not aware why some of the assessments were identified as no skin issues, or not evaluated. In addition, DON indicated she did not know what the number one represented in the skin progress notes listed above. DON indicated her expectation was that staff assessed pressure ulcers daily or every shift when competing skilled nursing assessments. During a telephone interview on 7/1/25 at 10:36 a.m. , RN-B indicated he thought he evaluated R1's deep tissue injury when observing R1 while she was in bed. RN-B was unable to describe the wound however, thought it looked kind of blackish, was not open and stated he could not remember for certain. RN-B stated there were no orders to observe R1's wound or any treatment plan. During a telephone interview on 7/1/25 at 11:37 a.m., RN-C indicated RN-C had been aware of R1's pressure ulcer and had documented it in R1's skills assessment and stated there was a place to check if there was no change. RN-C stated when RN-C had viewed R1's pressure ulcer, it was intact. During a telephone interview on 7/1/25 at 11:45 a.m. licensed practical nurse (LPN)-A indicated LPN-A had not been aware R1 had a pressure ulcer, until after R1 had been sent to the hospital. LPN-A stated R1 did not have any orders on her treatment administration record (TAR) to assess or treat a pressure ulcer. During a follow up interview on 7/1/25 at 11:29 a.m., DON indicated if a resident was receiving skilled services, the nurses were expected to assess the resident's skin each shift on the resident's skilled evaluation. DON stated if a long term resident had a pressure ulcer, she would place a nursing order in the electronic health record for nurses to assess the pressure ulcer daily. Review of the facility policy Pressure Injury Prevention And Management Policy dated 1/1/25, identified licensed nurses would conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings would be documented in the medical record. The policy identified monitoring would be completed by weekly wound assessments until resolved. The facility policy lacked identification of required daily monitoring of pressure ulcers.