STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245626	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rochester Rehabilitation and Living Center	1900 Ballington Boulevard NW Rochester, MN 55901

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** 38685 Based on observation, interview and document review the facility failed to comprehensively assess pressure ulcers and monitor for skin breakdown to prevent and/or mitigate the risk of deterioration resulting in actual harm when 1 of 1 residents (R1) admitted with a stage 1 pressure ulcer developed into an unstageable pressure ulcer that caused pain and required antibiotic treatment. Findings include: Definitions of pressure ulcers: Pressure Ulcer/Injury (PU/PI) is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. The appearance will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. 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 4 pressure ulcer will be revealed. R1's admission Minimum Data Set (MDS) dated [DATE] identified R1 had diagnoses of dementia and malnutrition. Further identified R1 was at risk for pressure ulcers. Interventions included a pressure reducing device for chair and bed. No pressure ulcers were identified on the MDS. R1's Braden Scale For Predicting Pressure Sore Risk assessment dated [DATE] identified a score of 16 indicated R1 was at risk for pressure ulcers. (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 Nursing Skilled Services Data Collection assessment, dated 7/29/24 identified R1 had a stage 1 pressure ulcer to the left buttock. R1's pressure ulcer assessment lacked measurements and description of pressure area, presence of pain, and lacked the treatment plan. Although the assessment identified a stage 1 pressure ulcer on 7/29/24, it was not evident R1's wound was comprehensively assessed nor ongoing monitoring was completed until 8/16/24, 18 days later when the record identified an unstageable pressure ulcer on R1's coccyx. R1's Nursing Skilled Services Data Collection assessment, dated 8/8/24 did not identify any skin concerns. R1's Incident-Post Incident Review note dated 8/16/24 at 6:00 p.m., identified R1 had an unstageable pressure ulcer to coccyx area, nursing assistant (NA)-C found the wound while changing R1's brief. R1's Nursing Skilled Services Data Collection assessment, dated 8/16/24 identified R1 had an unstageable pressure ulcer. The assessment did not identify where the pressure ulcer was or description. Interventions were to reposition more often, air mattress in place and to perform wound assessment with monitoring. R1's progress note dated 8/16/24 at 6:23 p.m., identified R1 had an unstageable pressure ulcer to the coccyx area measuring 1.4 centimeters (cm) x 2.4 cm with surrounding redness measuring 0.5 cm, area was cleansed and a Mepilex (absorbent foam dressing) was applied. Wound bed had 95% slough (white or yellow soft dead tissue) and 5% eschar (dry, black, or brown, hardened scab-like covering of dead tissue that forms over deep wounds). In review of R1's record, the care plan was not revised until 8/29/24 and no immediate interventions including wound treatments and monitoring were implemented until 8/20/24, 4 days after the wound was identified. Further not evident the wound was treated or monitored between 8/17/24 through 8/20/24. R1's Nurse Practitioner (NP) visit note dated 8/20/24 identified R1 had a bilateral gluteal cleft wound that measured 2.0 cm x 2.5 cm, irregularly shaped, macerated peri wound with 100% white/yellow slough in the wound bed. Assessment and plan: Remove old dressing cleanse with saline, pat dry, open capsule of metronidazole (antibiotic) and sprinkle on the wound. Cut silver alginate (wound dressing to treat infected wounds or high risk for infected wounds) dressing to size of wound. Cover with Mepilex dressing and change daily. R1's treatment administration record (TAR) dated August 2024, included the aforementioned physician treatment order however, identified R1's pressure ulcer treatment was not implemented until 8/21/24. R1's Skin and Wound Evaluation dated 8/23/24, identified R1 had an in house acquired unstageable pressure ulcer due to slough and/or eschar that was staged by a health care provider. Pressure ulcer measurements were 1.8 cm x 1.2 cm, 70% wound filled with slough, increased pain and warmth noted. Exudate was moderate serosanguineous drainage with no odor. Peri wound was warm, fragile, erythema (redness) and was excoriated (superficial loss of tissue). R1 was on antibiotic therapy for the wound, had some moderate pain in the area that was controlled with pain medications and pharmacological interventions. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's care plan revised 8/29/24 identified a focus, R1 has potential for pressure ulcer. Risk factors include pain development of PU/skin condition and fluid risk . Interventions dated 8/16/24 identified an air pressure mattress and on 8/29/24 indicated to reposition every two hours along with incontinence management, inspect skin daily and with cares, report any concerns to the nurse, monitor for signs and symptoms of infection, weekly wound progress assessment and daily monitoring of wound by nurse. During an observation on 9/9/24 at 1:37 p.m., R1 was lying in bed on her back. R1 stated, my butt is sore I just have to get up. R1 tried to reposition self in bed but was unsuccessful. Staff came in and toileted R1 and brought R1 back to bed and positioned R1 on her right side. R1 stated, yes that is better. During an interview on 9/9/24 at 10:29 a.m., via phone family member (FM)-A stated a nurse called her on 8/16/24 and told her that R1 had one little pressure ulcer upon admit they think she got it in the hospital. The nurse explained the facility had missed it until 8/16/24 when nursing had found the ulcer unstageable. R1 was supposed to discharge but could not now because R1 had to have wound care every day. R1's bottom had been very sore, R1 would grimace and moan. During an interview on 9/9/24 at 2:17 p.m., licensed practical nurse (LPN)-A stated there was an unstageable pressure ulcer on R1's coccyx and had changed the dressing this morning. The wound was looking better since the treatment had been started. LPN-A stated on admission we do a full body skin assessment; this would be documented under Data Collection assessment. Weekly skin checks were completed on each resident usually on their scheduled bath days. LPN-A stated pressure ulcer assessments and documentation needed to include the stage, wound bed, peri wound, drainage, measurements, and any signs and symptoms of infection. During an interview on 9/9/24 at 2:48 p.m., NA-C stated he worked on 8/16/24 and had helped R1 with incontinent care. NA-C indicated he had seen a Mepilex dressing on her coccyx that was not dated, was very soiled with bowel movement, and looked like it had been there for awhile. NA-C got the nurse to change the dressing, when the nurse took the dressing off of R1's wound it was bad looking and had black in it. NA-C remembered he had seen a Mepilex to the area a week prior that was not dated and questioned if the dressing he found on 8/16/24 was the same one. NA-C stated R1 would have pain with transfers and toileting in the coccyx area. During an interview on 9/9/24 at 2:30 p.m., licensed practical nurse (LPN)-B stated she worked on 8/16/24 when NA-C alerted her to go to R1's room to change the coccyx dressing. LPN-B stated R1 did not have any orders for a dressing at that time. When LPN-B went to R1's room, she removed the soiled Mepilex that had a large amount of yellow and brown pus. R1 had a large unstageable pressure ulcer to her coccyx that smelled bad, like dead skin and the wound bed was gray and black. LPN-B immediately reported to the nurse manager LPN-C. LPN-B stated that was on a Friday, when she came back on Monday August 19th, she went to assess R1's wound and change the dressing, however there was no dressing on R1's coccyx and there was not a physician ordered wound treatment. LPN-B again reported her findings to the nurse manager so a treatment order could be put into place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on 9/9/24 at 3:46 p.m., registered nurse (RN)-A and LPN-C indicated R1's unstageable pressure ulcer to the coccyx was first identified on 8/16/24. RN-A stated on 9/16/24 she measured the coccyx wound and LPN-C identified she documented RN-A's findings. RN-A indicated R1's wound was odd shaped and had eschar in it, there was no treatment order at that time. RN-A and LPN-C referenced the physician's standing orders for wound care which did not include a treatment for unstageable pressure ulcers, so it was determined to follow the treatment for a Stage 3 ulcer. RN-A cleaned the wound with normal saline and applied a Mepilex to it per the standing house orders. LPN-C stated she completed an SBAR (communication tool used to report changes to physician) for the nurse practitioner to notify and request treatment orders. Both RN-A and LPN-C stated they had not revised the care plan and/or developed nursing orders that would inform staff of the pressure ulcer, direct them to monitor the wound, and apply any wound dressings or treatments. Treatment orders were not ordered until 8/20/24 indicating R1's wound was not monitored and/or treated for 4 days. LPN-C indicated R1's skin assessment on 7/29/24, indicated R1 had a stage 1 pressure ulcer to coccyx and a full body skin assessment was not performed again until 8/25/24. RN-A stated full body skin assessments should be done on admit, weekly and with changes. RN-A stated when doing a wound assessment, it should be staged, measured, description of the wound bed, peri wound, drainage, pain, and any signs and symptoms of infection. Both LPN-C and RN-A indicated they had not completed record reviews or audits on other residents at risk for pressure ulcers and/or residents with existing wounds in order to determine if the care plan and treatment was appropriate. During an interview on 9/9/24 at 4:40 p.m., interim director of nursing (IDON) indicated upon admission residents should have a full comprehensive skin assessment, then weekly and with any changes. IDON stated with any skin changes family and provider were supposed to notified and also to ensure a treatment plan was in place. IDON stated to ensure a pressure ulcer was comprehensively assessed for treatment it should be staged, measured, description of the wound bed, peri wound, drainage, pain and any signs and symptoms of infection, IDON verified the facility policy was not followed for wound assessments and monitoring for R1. IDON stated since R1's wound was missed and the process was not followed the facility implemented an additional tracking system within the electronic health record with a plan for completing weekly skin inspections. However, the facility had not reviewed other residents possibly effected by the deficient practice which would include residents who were at risk for pressure ulcers and residents who had existing pressure ulcers. Facility, Standing Orders for Skilled Nursing Facilities, revised April 2022, identified under Skin and Wound Management to institute facility wound management if available. If facility wound management process not available .stage 2 or 3 Pressure injuries (moderate to heavy drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply adhesive foam dressing (facility stock); change every 2-3 days and prn. Notify provider next business day. Stage 2 or 3 Pressure injuries (minimal drainage): cleanse with normal saline or non-cytoxic wound cleanser. Apply hydrogel (facility stock) to wound bed. Cover with nonadherent dressing Change every 3 days and prn. Notify the provider the next business day. The Standing House orders does not identify a treatment for unstageable pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Facility policy reviewed, Prevention and Treatment of Pressure Ulcers/Pressure Injury, revised 11/22/22, identified It is the policy of Volunteers of America National Services (VOANS) to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to professional standards of care. I. Prevention of Pressure Ulcers: A. Braden Scale* and Skin Risk Data Collection form will be done: Upon admission, Weekly for the first 4 weeks post admission, Quarterly, and With a change in status (i.e., pressure ulcer development, change in mobility, continence status, change in cognition, nutrition, etc.). B. Nursing: Monitoring of Skin Integrity: Skin will be observed daily with cares by the nursing assistant. If any skin concerns are noted, they are to be reported immediately to the designated nurse. Weekly skin audits will be performed by the Licensed Nurse (Refer to Body Audit Policy and Procedure). An alert will trigger from question B of the assessment to the clinical dashboard that will notify the IDT that a new skin issue has occurred and follow up is needed. If a dressing is ordered, it will be monitored for appropriate placement on resident. If a skin concern is noted, refer to section II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) procedure and Wound Care Protocols. If the assigned nurse identifies a wound upon the admission body audit. The nurse will need to complete the 1st weekly wound documentation and notify resident and/or resident representative as appropriate and the Physician/PA/CNP will be notified and the nurse will obtain orders utilizing the 3 M Protocol, complete an individualized care plan, and notify the IDT. If post admission there is an identification of a wound, the assigned nurse will complete the E-Interact COC or Paper SBAR, complete the Risk Management New Skin Integrity Concern. The Care Plan for Skin Integrity is to be evaluated and revised based on response, outcomes, and needs of the resident. II. Treatment of Pressure Ulcers and Lower Extremity Ulcers (arterial, venous, neuropathy/diabetic, or mixed) If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented: 1. Notify Physician/PA/CNP and Resident and/or Resident Representative 2. Initiate physician wound orders or 3M Wound Care Protocols, until order is obtained. 3. Notify Supervisor/Designee as assigned. 4. Notify Dietary for nutritional interventions. 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions. 6. Notify other interdisciplinary team members as appropriate. 7. Initiate Braden Scale and Skin Risk Data Collection form. 8. Update the residents individualized Care Plan for Skin Integrity and nursing assistant Kardex with any skin concerns and interventions. Include appropriate risk factors, turning intervals and interventions as appropriate. 9. Initiate Weekly Wound Documentation to be completed every seven days and PRN in electronic health record which will include: type of wound, location, date, stage (pressure ulcers only) or indicate partial or full thickness (arterial, venous, neuropathy/diabetic ulcers), length, width, and depth; wound base description, wound edge description and if present: drainage, odor, undermining, tunneling, and/or pain. The Weekly Wound Documentation Progress Form should only have ONE WOUND per form. See Weekly Wound Documentation Progress Sheet & Wound Documentation Guidelines for instructions. 10. When a wound is present, daily wound monitoring should include: An evaluation of the wound, if no dressing is present, An evaluation of the status of the dressing, if present, The status of the area surrounding the ulcer/wound (that can be observed without removing the dressing), The presence of possible complications, such as signs of infections, Whether pain, if present, is being adequately controlled. Document on any changes or concerns in the nurses notes and re-evaluate prior steps 1-9 as appropriate. 11. Periodically IDT team review the resident for intervention for prevention and healing of pressure ulcer/pressure injury. 12. Notify the Physician/CNP, Resident and/or Resident Representative as appropriate and Supervisor/Designee if the ulcer(s) has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to ensure enhanced barrier precautions (EBP)-(an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) were implemented for management of a pressure ulcer wound to reduce the risk of infection to others for 1 of 1 resident (R1) reviewed for transfers. Further the facility failed to implement hand hygiene for 1 of 1 resident (R1) observed during toileting and transfers. Findings include: R1's significant change Minimum Data Set (MDS) dated [DATE] identified R1 had diagnoses of dementia and a urinary tract infection (UTI) within the last 30 days. Further identified R1 was at risk for pressure ulcers, had one unstageable pressure ulcer and was on antibiotics. R1's progress note dated 8/16/24 at 6:23 p.m., identified R1 had an unstageable pressure ulcer to the coccyx area measuring 1.4 centimeters (cm) x 2.4 cm with surrounding redness measuring 0.5 cm, area was cleansed and a Mepilex (absorbent foam dressing) was applied. Wound bed had 95% slough (white or yellow soft dead tissue) and 5% eschar (dry, black, or brown, hardened scab-like covering of dead tissue that forms over deep wounds). R1's care plan dated 8/19/24 identified a focus, resident had a wound and meets the criteria of enhanced barrier precautions. Intervention indicated to don gown and gloves during high-contact resident care activities: dressing, bathing/showering, providing hygiene, changing linens, changing briefs, and assist with toileting. R1's order summary dated 8/20/24 identified R1's wound care to coccyx. Remove old dressing cleanse with saline, pat dry, open capsule of metronidazole (antibiotic) and sprinkle on the wound. Cut silver alginate (wound dressing to treat infected wounds or high risk for infected wounds) dressing to size of wound. Cover with Mepilex dressing and change daily. During an observation on 9/9/24 at 1:36 p.m., upon entrance to R1's room an orange paper sign was lying on top of a white cart with drawers to the right entrance of the room. Two red colored, STOP signs noted at the top on either side. Signage read: ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following activities. Dressing, Bathing/Showering, Transferring, Changing linens, Providing Hygiene, Changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. The sign also had color pictures of hand cleanser, gloves, and gown. During an observation and on 9/9/24 at 1:37 p.m., nursing assistant (NA)-A walked into R1's room without doing hand hygiene, did not utilize gloves or a gown. NA-A then transferred R1 from the bed to the wheelchair, then again from R1's wheelchair to the toilet. NA-A did not perform hand hygiene after the transfer to the toilet. NA-A walked out of the room without doing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/24 at 1:49 p.m., NA-A was unaware they had to use gowns and gloves for high contact care activities. NA-A indicated she did not wash her hands and should have. During an interview on 9/9/24 at 2:01 p.m., LPN-B stated staff should be using EBP with all cares for R1 due to a pressure ulcer. During an observation on 9/9/24 at 2:17 p.m., NA-B transferred R1 from the toilet to the wheelchair. NA-B and licensed practical nurse (LPN)-A transferred R1 from the wheelchair to the bed with no hand hygiene performed before or after and without gown or gloves. NA-B was unable to articulate when to use EBP. During an interview on 9/9/24 at 2:18 p.m., LPN-A stated all staff should be utilizing EBP to include gown and glove use with high resident care activities such as transfers and toileting if they have a pressure ulcer to help prevent the spread of infection and hand hygiene should be performed before and after cares. LPN-B stated hand hygiene should be performed before and after cares and admitted it was not done. During an interview on 9/9/24 at 2:30 p.m., LPN-B stated all staff should be utilizing EBP to include gown and glove use with high resident care activities such as transfers and toileting if they have a pressure ulcer to help prevent the spread of infection. During an interview on 9/9/24 at 4:31 p.m., registered nurse (RN)-A stated, for a resident who has a pressure ulcer EBP precautions should be used with all high-risk resident activities including transfers and toileting. During an interview on 9/9/24 at 4:40 p.m., interim director of nursing (IDON) indicated staff should be using EBP's with transfers and toileting for R1 due to the pressure ulcer of the coccyx to help prevent the spread of infection. All residents with EBP have a sign clearly posted outside their room and staff should be looking for that and following the policy for EBP to help prevent the spread of infection. IDON further indicated All staff should be utilizing hand hygiene before and after resident cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy, enhance Barrier Precautions Policy and Procedure, revised 7/2/24, identified, It is the policy of this Volunteers of America National Services (VOANS) that Enhanced Barrier Precautions (EBP), in addition to Standard and Contact Precautions will be implemented during high contact resident care activities when caring for residents that have an increase risk from acquiring a multi-drug resistant organism (MDRO) such as a resident with wounds, indwelling medical devices or residents with infection or colonization with an MDRO. Several routes transmit microorganisms in healthcare facilities. Moreover, more than one route may transmit the same organism. Enhanced Barrier Precautions (EBP) is intended to prevent the spread of novel or targeted Multi-drug Resistant Organism (MDROs) when residents have an infection or colonization with a MDRO or if the resident has a wound or indwelling medical device, regardless of MDRO infection or colonization. When a resident contracts a MDRO, treatment is many times limited. Enhanced Barrier Precautions will not only focus on residents with infection or colonization with MDROs but will also address residents at risk for developing or becoming colonized. Focusing only on residents with active infection fails to address the continued risk of transmission from residents with MDRO colonization, who, by definition, have no symptoms of illness. MDRO colonization may persist for long periods of time (e.g., months) which contributes to the silent spread of MDROs. Enhanced Barrier Precautions are precautions that are between Standard Precautions and Contact Precautions. Enhanced Barrier Precautions require gown and glove use for residents with a novel or targeted MDRO or any resident with a wound or indwelling medical device during specific high-contact resident care activities . The purpose of Enhanced Barrier Precautions is to prevent opportunities for transfer of MDRSs to employee's hands and clothing during cares, beyond situations in which staff anticipate exposure to blood and body fluids. High-Contact Resident Care Activities include: Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing linens, Changing incontinent products or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care; any skin opening requiring a dressing. (This generally includes chronic wound such as pressure ulcers, diabetic ulcers, and chronic venous stasis ulcers. This does not include those with shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Ostomies, such as colostomies and ileostomies, are not defined as a wound or and indwelling medical device for indication for Enhanced Barrier Precautions).