

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2025
NAME OF PROVIDER OR SUPPLIER St Catherines Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1307 N 7th St Wahpeton, ND 58075	

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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52000</p> <p>Based on record review, review of facility policies, and staff interview, the facility failed to provide the necessary care and treatment for 1 of 2 sampled residents (Resident #2) with impaired skin integrity of the feet/toes. Failure to assess, monitor, and treat skin issues in a timely manner resulted in a delay of treatment and contributed to Resident #2's hospitalization for amputation of fourth and fifth toes.</p> <p>Findings include:</p> <p>Review of the facility policy titled Prevention and Treatment of Skin Breakdown occurred on 03/11/25. This policy, dated 09/01/18, stated, . Skin integrity is monitored and abnormal findings are documented: Skin is observed daily with cares.</p> <p>Review of the facility policy titled Change in Condition occurred on 03/11/25. This policy, revised 10/02/23, stated, . Update the care plan as appropriate.</p> <p>Review of Resident #2's medical record occurred on 03/11/25. Diagnoses included peripheral vascular disease (PVD). Resident #2 tested positive for COVID (Coronavirus disease) and was placed in isolation from February 9-16, 2025.</p> <p>A physician's order, dated 02/11/24, stated, Monitor the wound every 7 days to include measurements. Notify MD [physician] if no change in 2 weeks</p> <p>Review of Resident #2's care plan identified the following:</p> <ul style="list-style-type: none"> * Skin treatment as ordered and/or as needed. * Report any signs of skin breakdown (sore, tender, red or broken areas). <p>Review of Resident #2's progress notes identified the following:</p> <ul style="list-style-type: none"> * 02/10/25 at 1:37 p.m., SKIN ASSESSMENT In-between 4th and 5th toe on left. <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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>4th toe, inner medial [in the middle]; eschar [dry, thick, leathery skin] noted measuring W [width] 0.7 cm [centimeter] X [by] L [length] 0.5 cm. Surrounding skin light red and blanchable [redness to the skin disappears when pressure is applied and reappears when pressure is released]. 5th toe, inner medial; eschar noted measuring W 2.2 cm X L 1.1 cm. Surrounding skin light red and blanchable. Anterior [in the front] toes also light red and blanchable. Not warm to the touch. Area cleansed with saline and gaze [sic]. Area covered with betadine [topical antiseptic] and Vaseline gauze, secured in place with dressing. Orders placed [no orders found in the resident's medical record] for dressing change every 3 days. PA [physician's assistant] informed and will assess when in house on 2/12/25.</p> <p>* 02/11/25 at 9:08 a.m., . IDT [interdisciplinary team] met to review plan of care. Nursing continues to monitor COVID symptoms and skin with new wounds to left 4th and 5th toes.</p> <p>* 02/12/25 at 11:12 a.m., Wounds to 4th and 5th toe, left assessed by [name of PA] Resident to be seen by podiatry once off of Isolation precautions.</p> <p>* 02/13/25 at 9:11 a.m., IDT met to review plan of care. Nursing continues to monitor COVID symptoms and skin with new wounds to left 4th and 5th toes.</p> <p>* 02/18/25 at 1:25 p.m., PA in facility for rounds. Notified regarding resident's left 4th and 5th toe. 5th toe appears to have black discoloration with inner aspect appearing to have black eschar. 4th toe appears purple in color with medial aspect of toe covered with black eschar, surrounding skin is red . Resident verbalized not [NAME] [sic] able to sleep last night due to pain to area. PA recommendation to have resident sent to [name of hospital] ER [emergency room] for further evaluation and intervention.</p> <p>* 02/18/25 at 3:36 p.m., Resident has been hospitalized at [location of hospital] for possible PVD & foot infection.</p> <p>* 02/24/25 at 2:30 p.m., Note Text: Resident Returned from [name of hospital] Hospital at 12pm [12:00 p.m.] following admission for amputation of 4th and 5th toe, left d/t [due to] gangrene [death of skin tissue]. Resident denies pain. Dressing noted to left foot and is to stay in place until 1 [one] week follow up with provider, per orders. Nursing to monitor every shift to ensure dressing is CDI [clean, dry, intact]. Darco [brand of protective shoe] shoe to be worn when up with reminder to have resident put pressure on heel when standing.</p> <p>The February 2025 treatment administration record lacked documentation of skin assessment/treatment, and the electronic health record (EHR) lacked the orders for a dressing change every three days as stated in the progress note dated 02/10/25. The nurse documented a weekly skin check on 02/13/25, but failed to identify/assess the impaired skin integrity on resident #2's toes.</p> <p>The EHR lacked a progress note from the PA's inhouse visit on 02/12/25.</p> <p>During an interview on the afternoon of 03/11/25 an administrative nurse (#1) confirmed the PA did not document an assessment/progress note and/or orders from the visit on 02/12/25.</p> <p>The facility failed to initiate treatment for toe wounds in a timely manner, assess, monitor, and document abnormal skin conditions daily, ensure the availability of PA notes post visit, and effectively communicate with the provider regarding treatment.</p>		