DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 4, 2021

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: August 25, 2021

Dear Administrator:

On September 15, 2021, we notified you a remedy was imposed. On September 30, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 27, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 30, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 15, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 30, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 27, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 4, 2021

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

Re: Reinspection Results
Event ID: DOBI12

Dear Administrator:

On September 30, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 25, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
September 15, 2021

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: August 25, 2021

Dear Administrator:

On August 25, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 30, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 30, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 30, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 30, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, New Brighton A Villa Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 30, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON A VILLA CENTER	**825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/23/21 to 8/25/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5164194C (MN75832 / MN75830), with a deficiency cited at F686 and F692. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		9/27/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/17/2021

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F 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to properly assess and monitor pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. R1 had been admitted from the hospital with existing pressure ulcers, and the pressure ulcers were not monitored or assessed. This resulted in harm to R1, when a pressure ulcer on his coccyx worsened and he sustained a new pressure ulcer to his ankle. Pressure Ulcer definitions by the National Pressure Injury Advisory Panel: 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. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present.	F 686	1. R1 is no longer a resident at the facility 2. All residents with pressure ulcers were assessed for accurate staging, treatment, and interventions. 3. Nursing staff has been educated on turning & repositioning, staging and treatment of pressure ulcers and pressure relieving devices, weekly skin assessments and documentation. 4. The Director of Nursing/Designee will audit turning/repositioning and use of pressure relieving devices 3 times weekly for 4 weeks and then report results to QAPI for further guidance. The Director of Nursing will audit skin assessment and documentation weekly for 4 weeks and then report results to QAPI for further guidance.	

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F 686	Continued From page 2	F 686		

Stage 3 Pressure Ulcer: Full-thickness skin loss:
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 and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed.

Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss:
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location.

Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss:
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. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be

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F 686	Continued From page 3	F 686		

completely debrided or free of all slough or eschar for reclassification of stage to occur.

Findings include:

R1's Face Sheet printed 8/24/21, indicated R1 was admitted from the hospital on 5/20/21. R1's diagnoses included infection of left amputation stump, chronic osteomyelitis (infection of the bone) of the left lower leg, diabetes with diabetic neuropathy, third degree burn to middle finger, and severe morbid obesity.

R1's admission Minimum Data Set (MDS) dated 5/27/21, indicated R1 was cognitively intact, and required extensive assistance from two staff for bed mobility and transfers. The MDS further incorrectly indicated R1 had one Stage 1 pressure ulcer and was at risk for pressure ulcers. The MDS lacked further record of Stage 2, Stage 3, or Stage 4 pressure ulcers.

R1's Care Area Assessment (CAA) for Pressure Ulcer and Injury dated 5/27/21, indicated R1 was at increased risk of skin breakdown. The CAA further indicated R1 had a Stage 1 pressure ulcer to buttocks which was being treated by Triad creme (a sterile coating applied directly onto the wound or peri-wound as a moisture barrier). The CAA indicated R1 required assistance of two staff with bed mobility and was an extensive assist of two for bed mobility, and since he was always incontinent of bladder and frequently incontinent of bowel, he required extensive assistance with toileting. The CAA indicated R1 was at risk for skin breakdown.

R1's care plan last updated 8/9/21, indicated R1 had actual impairment to skin integrity on his

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F 686	Continued From page 4	F 686		

buttock and left lower leg, and a lower knee amputation related to pressure ulcers. R1's care plan also indicated R1 could be resistive to repositioning every two hours, and was to be up in chair daily.

R1's hospital discharge summary dated 5/20/21, indicated R1 admitted from the hospital to the facility and identified the following existing pressure ulcers on 5/19/21:
- Left buttock pressure ulcer Stage 3, measured at 7 centimeters (cm) x 5 cm x 0.3 cm
- Right buttock pressure ulcer Stage 2 vs, Stage 3. Two open areas measuring 1.2 cm x 0.5 cm x 0.1 cm and 0.5 cm x 0.7 cm x 0.1 cm
- Right isheal tuberosity (sitting bones) Stage 2 vs. Stage 3. This area was not measured
- Right buttock with large area of devitalized skin (slough or necrotic tissue). Skin appears intact under this area, will monitor as devitalized skin peels away.

On 5/20/21, at 12:52 p.m. a progress note the day of R1's admission, indicated the following pressure ulcers that were not measured, staged or accurately assessed:
- Wound to both buttocks.
R1's medical record lacked assessment and documentation of the pressure ulcer to R1's isheal tuberosity.

On 5/20/21, at 9:28 p.m. a progress note indicated R1's condition upon admission included a skin ulcer on R1's sacrum (tailbone) limited to breakdown of skin. The progress note lacked assessment of the pressure area on R1's sacrum.

On 6/9/21, at 4:55 p.m. a Wound Assessment

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F 686	Continued From page 5	F 686		

completed by the assistant director of nursing (ADON) indicated R1's coccyx (tailbone) pressure ulcer was a healed Stage 1, with erythema (redness). No further assessment of the pressure ulcer was completed. R1's medical record lacked assessment and monitoring.

On 6/24/21, at 4:17 p.m. a Wound Assessment of R1's coccyx completed by the ADON indicated the pressure ulcer as a healed Stage 1. No further assessment of the pressure ulcer was completed.

On 7/6/21, a Skin Observation described R1's skin issues as wound healing buttocks and lower abdomen. The Observation lacked any further assessment. R1's medical record lacked any further assessment or monitoring.

On 8/1/21, a Skin Observation described R1's skin issues as shearing to left buttock irregular areas. R1 stated he was not scratching it. The Observation lacked any further assessment.

On 8/9/21, at 3:39 p.m. a Wound Assessment to R1's right outer ankle completed by the ADON, indicated the pressure ulcer was unstagable, and measured 3.0 am x 2.5 cm with an unknown depth. R1's medical record lacked documentation of when this pressure ulcer developed, and lacked assessment and monitoring.

On 8/11/21, at 4:09 p.m. a Wound Assessment to R1's coccyx was completed by the ADON. The Assessment indicated the pressure ulcer was a Stage 3 and measured 5.0 cm x 4.0 cm with an unknown depth. This documentation indicated R1's coccyx pressure ulcer had worsened, having

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F 686	Continued From page 6	F 686		

gone from a healed Stage 1 pressure ulcer, to a Stage 3 pressure ulcer.

On 8/13/21 at 4:04 a.m. a progress note indicated R1 requested to be sent to the emergency department (ED) initially at 2:00 a.m. due to ongoing complaints of pain after already receiving pain medication. Ultimately, R1 called the paramedics himself and left the facility via ambulance.

R1'a Hospital discharge dated 8/16/21, indicated R1 had the following pressure ulcers:
- Sacrum pressure ulcer was staged at unstageable, and measured 3 cm x 2.5 cm x 0.2 cm
- Right ankle was staged at unstabeable and measured 2.5 cm x 2.5 cm x 0.5 cm lateral and 1.5 cm x 1.5 cm x 0 cm medial

On 8/23/21, 1:19 p.m. the director of nursing (DON) was interviewed and stated there were no other assessments of R1's pressure ulcers except what was in the medical record. The DON stated R1's largest pressure ulcer on his buttocks had healed or was closed upon admission, which was the reason why weekly pressure ulcer documentation did not start. The DON stated after the assessment on 6/9/21, there was a lack of further measurements of the pressure ulcer on R1's buttocks or coccyx area until the assessment on 8/11/21. The DON stated at that time, R1's coccyx was assessed at a Stage 3 pressure ulcer. The DON stated the facility's process was to assess pressure ulcers over a week span, and if a pressure ulcer slowed in healing for over two weeks, they would change the treatment plan.

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F 686	Continued From page 7	F 686		

On 8/24/21, at 7:12 a.m. R1 was interviewed and stated he had left the facility due to inadequate care. R1 stated he felt his overall cares, including the lack of treatment for his pressure ulcers, were going to worsen if he did not leave the early morning of 8/13/21, which was why he called 911.

On 8/24/21, at 4:30 p.m. the medical director (MD)-A was interviewed and stated the ADON's pressure ulcer assessment on 6/9/21, as a healed Stage 1 on R1's coccyx was incorrect. MD-A stated she did some staff education some time the end of May or June, when she noticed the ADON was not assessing the pressure ulcers accurately. MD-A stated she noted issues with the R1's pressure ulcer documentation. MD-A stated the redness and the measurements were "a little off kilter," and the description of the wound bed was lacking. MD-A stated this was due to staff's lack of knowledge. MD-A stated a pressure ulcer was not healed if there was some excoriation and moisture associated skin damage, they would be staged as a Stage 2, not a Stage 1. MD-A stated she expected nursing staff to do a very thorough assessment on pressure ulcers.

The facility policy Skin Protection and Prevention dated 7/7/21, directed our facility applies a process to identify residents with or at risk for developing a pressure injury: Upon admission / readmission, transfer out/in, with significant changes in condition routinely through the MDS Assessment process. the policy further directed the first step in the prevention of pressure ulcers/pressure injuries (PU/PIs) is the identification of the resident at risk. A pressure ulcer/injury can occur wherever pressure has impaired circulation to the tissue. Some factors

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	245164	A. BUILDING _____ B. WING _____	C 08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON A VILLA CENTER	**825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

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F 686	Continued From page 8 are modifiable whiles others are not.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely implement recommendations for a speech evaluation and a registered dietician recommendations for 1 of 1 residents (R1) reviewed for nutritional maintenance to promote wound healing. R1's Face Sheet printed 8/24/21, indicated R1 was admitted from the hospital on 5/20/21. R1's diagnoses included infection of left amputation stump, left lower leg chronic osteomyelitis	F 692	1. R1 is no longer a resident at the facility 2. All residents with the potential for swallowing difficulties and nutritional problems were assessed. 3. Nursing staff has been educated on identifying and reporting swallowing difficulties, pain during eating/swallowing and identifying potential for weight loss.	9/27/21

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F 692	Continued From page 9 (infection of the bone), diabetes with diabetic neuropathy, severe morbid obesity and gastro-esophageal reflux disease. R1's admission Minimum Data Set (MDS) dated 5/27/21, indicated R1 was cognitively intact, and had complaints of difficulty in swallowing. MDS further indicated R1 had one Stage 1 pressure ulcer and was at risk for pressure ulcers. The MDS lacked identification of any other pressure ulcers. R1's care plan updated 5/21/21, indicated R1 had a swallowing problem related to difficulty and pain while seated upright for oral intake, as well as having a history of choking. R1's care plan noted an intervention of refer to speech therapy for swallowing evaluation. R1's care plan updated 5/21/21, indicated R1 had nutritional problems or potential nutritional problem related to a history of left below knee amputation (BKA) with wound to stump. Intervention included to provide supplements as ordered 120 milliliters (mL) Strawberry Mighty Shake (nutritional supplement) twice daily. R1's CAA for Nutritional Status dated 5/27/21, indicated R1 was at increased nutritional risk due to secondary to dysphagia (swallowing difficulty), edentulous (lack of teeth), left BKA, diabetes, high blood pressure,and infection of the tonsils. The CAA further indicated a referral was needed to speech therapy (ST) for dysphagia. R1's comprehensive Nutrition Assessment dated 5/21/21, indicated R1 had problems chewing and swallowing. The assessment also indicated R1 had poor dentation and a ST evaluation was	F 692	4. The Director of Nursing/Designee will audit weight loss, reported swallow and pain with swallowing issues 3 times per week for 4 weeks. The Director of Nursing will report results to QAPI for further guidance.	

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F 692	Continued From page 10	F 692		

indicated. R1 had complained of swallowing difficulty and of having a choking episode while in hospital. R1 was also unable to sit fully upright at meals related to pain. The assessment further directed staff to provide 120 mL Strawberry Mighty Shake twice a day.

R1's order summary indicated the following orders:
- Effective 7/29/21: ST clarification: three times a week for four weeks for swallowing treatment. Order date 7/30/21.
- Interventional radiology referral for sonogram (swallow study) per speech-language pathologist (SLP) recommendations due to ongoing dysphagia, and gastroesophageal reflux disease (GERD).

On 7/28/21, at 1:05 p.m. a progress note indicated the Associated Clinic of Psychology (ACP) notes from 7/27/21, were reviewed. R1 mentioned he has been having difficulty swallowing. Request for a referral to SLP emailed to rehab manager and transitional care unit nurse manager (TCU NM) .

On 8/24/21, at 12:02 p.m. the assistant director of nursing (ADON) was interviewed. The ADON stated he submitted the referral for a swallow evaluation to be completed to the health unit coordinator (HUC) and was unable to confirm or explain why R1 had not had a been scheduled for swallow evaluation, even though it was noted in R1's care plan on 5/21/21.

On 8/24/21, at 12:56 p.m. the registered dietitian (RD)-A was interviewed. RD-A stated she was able to meet with R1 once related to his pressure ulcers, and she had made the recommendation of

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F 692	Continued From page 11	F 692		

Mighty Shakes for increased protein intake, which would benefit R1 in the healing process of his wounds. RD-A stated prior to her visit, R1 was not receiving Mighty Shakes as she had wanted to trial it first to see if R1 would be able to keep it down due to his nausea. RD-A also confirmed the Mighty Shakes had been ordered since R1's admission on 5/20/21.

On 8/24/21, at 1:17 p.m. SP-A was interviewed and stated R1 had been referred to ST, but on 5/21/21, there was not a "concrete" referral, and and she only started working with R1 on 7/30/21. SP-A stated when she saw R1 on 8/11/21, he was agreeable to going into the hospital to conduct the swallow evaluation. ST-A stated this was supposed to be scheduled, however, facility documentation lacked evidence of scheduling attempts.

The facility policy titled Nutritional Status Management dated 4/2/18, directed it is important to maintain adequate nutritional status, to the extent possible, to ensure each resident is sable to maintain the highest practicable level of well-being. The early identification of residents with, or at risk for, impaired nutrition or hydration status may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. Body weight and laboratory results can often be stabilized or improved with time but may not be correctable in some individuals. Intake alone, is not the only factor that can affect nutritional status. Resident conditions and co-morbidities may prevent improved nutritional or hydration status, despite improved intake.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 15, 2021

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: DOBI11

Dear Administrator:

The above facility was surveyed on August 23, 2021 through August 25, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/23/21, to 8/25/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5164194C (MN75832 / MN75830) with licensing orders issued at 0900 and 0940. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to properly assess and monitor pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. R1 had been admitted from the hospital with existing pressure ulcers, and the pressure ulcers were not monitored or assessed. This resulted in harm to R1, when a pressure ulcer on his coccyx worsened and he sustained a new pressure ulcer to his ankle.	2 900	corrected	9/27/21

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2 900	Continued From page 3 Pressure Ulcer definitions by the National Pressure Injury Advisory Panel: 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. Color changes of intact skin may also indicate a deep tissue PI (see below). Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis: Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Stage 3 Pressure Ulcer: Full-thickness skin loss: 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 and/or eschar may be visible but does not obscure the depth of tissue loss. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss: Full-thickness skin and tissue loss with exposed	2 900		

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2 900	Continued From page 4 or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible on some parts of the wound bed. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss: 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. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur. Findings include: R1's Face Sheet printed 8/24/21, indicated R1 was admitted from the hospital on 5/20/21. R1's diagnoses included infection of left amputation stump, chronic osteomyelitis (infection of the bone) of the left lower leg, diabetes with diabetic neuropathy, third degree burn to middle finger, and severe morbid obesity. R1's admission Minimum Data Set (MDS) dated 5/27/21, indicated R1 was cognitively intact, and required extensive assistance from two staff for	2 900		

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2 900	Continued From page 5 bed mobility and transfers. The MDS further incorrectly indicated R1 had one Stage 1 pressure ulcer and was at risk for pressure ulcers. The MDS lacked further record of Stage 2, Stage 3, or Stage 4 pressure ulcers. R1's Care Area Assessment (CAA) for Pressure Ulcer and Injury dated 5/27/21, indicated R1 was at increased risk of skin breakdown. The CAA further indicated R1 had a Stage 1 pressure ulcer to buttocks which was being treated by Triad creme (a sterile coating applied directly onto the wound or peri-wound as a moisture barrier). The CAA indicated R1 required assistance of two staff with bed mobility and was an extensive assist of two for bed mobility, and since he was always incontinent of bladder and frequently incontinent of bowel, he required extensive assistance with toileting. The CAA indicated R1 was at risk for skin breakdown. R1's care plan last updated 8/9/21, indicated R1 had actual impairment to skin integrity on his buttock and left lower leg, and a lower knee amputation related to pressure ulcers. R1's care plan also indicated R1 could be resistive to repositioning every two hours, and was to be up in chair daily. R1's hospital discharge summary dated 5/20/21, indicated R1 admitted from the hospital to the facility and identified the following existing pressure ulcers on 5/19/21: - Left buttock pressure ulcer Stage 3, measured at 7 centimeters (cm) x 5 cm x 0.3 cm - Right buttock pressure ulcer Stage 2 vs, Stage 3. Two open areas measuring 1.2 cm x 0.5 cm x 0.1 cm and 0.5 cm x 0.7 cm x 0.1 cm - Right isheal tuberosity (sitting bones) Stage 2 vs. Stage 3. This area was not measured	2 900		

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2 900	Continued From page 6 - Right buttock with large area of devitalized skin (slough or necrotic tissue). Skin appears intact under this area, will monitor as devitalized skin peels away. On 5/20/21, at 12:52 p.m. a progress note the day of R1's admission, indicated the following pressure ulcers that were not measured, staged or accurately assessed: - Wound to both buttocks. R1's medical record lacked assessment and documentation of the pressure ulcer to R1's isheal tuberosity. On 5/20/21, at 9:28 p.m. a progress note indicated R1's condition upon admission included a skin ulcer on R1's sacrum (tailbone) limited to breakdown of skin. The progress note lacked assessment of the pressure area on R1's sacrum. On 6/9/21, at 4:55 p.m. a Wound Assessment completed by the assistant director of nursing (ADON) indicated R1's coccyx (tailbone) pressure ulcer was a healed Stage 1, with erythema (redness). No further assessment of the pressure ulcer was completed. R1's medical record lacked assessment and monitoring. On 6/24/21, at 4:17 p.m. a Wound Assessment of R1's coccyx completed by the ADON indicated the pressure ulcer as a healed Stage 1. No further assessment of the pressure ulcer was completed. On 7/6/21, a Skin Observation described R1's skin issues as wound healing buttocks and lower abdomen. The Observation lacked any further assessment. R1's medical record lacked any further assessment or monitoring.	2 900		

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2 900	Continued From page 7 On 8/1/21, a Skin Observation described R1's skin issues as shearing to left buttock irregular areas. R1 stated he was not scratching it. The Observation lacked any further assessment. On 8/9/21, at 3:39 p.m. a Wound Assessment to R1's right outer ankle completed by the ADON, indicated the pressure ulcer was unstagable, and measured 3.0 am x 2.5 cm with an unknown depth. R1's medical record lacked documentation of when this pressure ulcer developed, and lacked assessment and monitoring. On 8/11/21, at 4:09 p.m. a Wound Assessment to R1's coccyx was completed by the ADON. The Assessment indicated the pressure ulcer was a Stage 3 and measured 5.0 cm x 4.0 cm with an unknown depth. This documentation indicated R1's coccyx pressure ulcer had worsened, having gone from a healed Stage 1 pressure ulcer, to a Stage 3 pressure ulcer. On 8/13/21 at 4:04 a.m. a progress note indicated R1 requested to be sent to the emergency department (ED) initially at 2:00 a.m. due to ongoing complaints of pain after already receiving pain medication. Ultimately, R1 called the paramedics himself and left the facility via ambulance. R1'a Hospital discharge dated 8/16/21, indicated R1 had the following pressure ulcers: - Sacrum pressure ulcer was staged at unstageable, and measured 3 cm x 2.5 cm x 0.2 cm - Right ankle was staged at unstabeable and measured 2.5 cm x 2.5 cm x 0.5 cm lateral and 1.5 cm x 1.5 cm x 0 cm medial	2 900		

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2 900	Continued From page 8 On 8/23/21, 1:19 p.m. the director of nursing (DON) was interviewed and stated there were no other assessments of R1's pressure ulcers except what was in the medical record. The DON stated R1's largest pressure ulcer on his buttocks had healed or was closed upon admission, which was the reason why weekly pressure ulcer documentation did not start. The DON stated after the assessment on 6/9/21, there was a lack of further measurements of the pressure ulcer on R1's buttocks or coccyx area until the assessment on 8/11/21. The DON stated at that time, R1's coccyx was assessed at a Stage 3 pressure ulcer. The DON stated the facility's process was to assess pressure ulcers over a week span, and if a pressure ulcer slowed in healing for over two weeks, they would change the treatment plan. On 8/24/21, at 7:12 a.m. R1 was interviewed and stated he had left the facility due to inadequate care. R1 stated he felt his overall cares, including the lack of treatment for his pressure ulcers, were going to worsen if he did not leave the early morning of 8/13/21, which was why he called 911. On 8/24/21, at 4:30 p.m. the medical director (MD)-A was interviewed and stated the ADON's pressure ulcer assessment on 6/9/21, as a healed Stage 1 on R1's coccyx was incorrect. MD-A stated she did some staff education some time the end of May or June, when she noticed the ADON was not assessing the pressure ulcers accurately. MD-A stated she noted issues with the R1's pressure ulcer documentation. MD-A stated the redness and the measurements were "a little off kilter," and the description of the wound bed was lacking. MD-A stated this was due to staff's lack of knowledge. MD-A stated a pressure	2 900		

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2 900	Continued From page 9 ulcer was not healed if there was some excoriation and moisture associated skin damage, they would be staged as a Stage 2, not a Stage 1. MD-A stated she expected nursing staff to do a very thorough assessment on pressure ulcers. The facility policy Skin Protection and Prevention dated 7/7/21, directed our facility applies a process to identify residents with or at risk for developing a pressure injury: Upon admission / readmission, transfer out/in, with significant changes in condition routinely through the MDS Assessment process. the policy further directed the first step in the prevention of pressure ulcers/pressure injuries (PU/PIs) is the identification of the resident at risk. A pressure ulcer/injury can occur wherever pressure has impaired circulation to the tissue. Some factors are modifiable whiles others are not. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate staff regarding the importance of pressure ulcer prevention measures including turning/repositioning and pressure-relieving devices. The director of nursing or designee could develop a schedule for weekly skin assessments and require documentation of assessments in the electronic record. The director of nursing, or designee, could conduct routine audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered	2 940		9/27/21

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2 940	Continued From page 10 and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to timely implement recommendations for a speech evaluation and a registered dietician recommendations for 1 of 1 residents (R1) reviewed for nutritional maintenance to promote wound healing. R1's Face Sheet printed 8/24/21, indicated R1 was admitted from the hospital on 5/20/21. R1's diagnoses included infection of left amputation stump, left lower leg chronic osteomyelitis (infection of the bone), diabetes with diabetic neuropathy, severe morbid obesity and gastro-esophageal reflux disease. R1's admission Minimum Data Set (MDS) dated 5/27/21, indicated R1 was cognitively intact, and had complaints of difficulty in swallowing. MDS further indicated R1 had one Stage 1 pressure ulcer and was at risk for pressure ulcers. The MDS lacked identification of any other pressure ulcers. R1's care plan updated 5/21/21, indicated R1 had a swallowing problem related to difficulty and pain while seated upright for oral intake, as well as having a history of choking. R1's care plan noted an intervention of refer to speech therapy for swallowing evaluation. R1's care plan updated 5/21/21, indicated R1 had nutritional problems or potential nutritional problem related to a history of left below knee	2 940	Corrected	

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2 940	Continued From page 11	2 940		

amputation (BKA) with wound to stump. Intervention included to provide supplements as ordered 120 milliliters (mL) Strawberry Mighty Shake (nutritional supplement) twice daily.

R1's CAA for Nutritional Status dated 5/27/21, indicated R1 was at increased nutritional risk due to secondary to dysphagia (swallowing difficulty), edentulous (lack of teeth), left BKA, diabetes, high blood pressure,and infection of the tonsils. The CAA further indicated a referral was needed to speech therapy (ST) for dysphagia.

R1's comprehensive Nutrition Assessment dated 5/21/21, indicated R1 had problems chewing and swallowing. The assessment also indicated R1 had poor dentation and a ST evaluation was indicated. R1 had complained of swallowing difficulty and of having a choking episode while in hospital. R1 was also unable to sit fully upright at meals related to pain. The assessment further directed staff to provide 120 mL Strawberry Mighty Shake twice a day.

R1's order summary indicated the following orders:
- Effective 7/29/21: ST clarification: three times a week for four weeks for swallowing treatment. Order date 7/30/21.
- Interventional radiology referral for sonogram (swallow study) per speech-language pathologist (SLP) recommendations due to ongoing dysphagia, and gastroesophageal reflux disease (GERD).

On 7/28/21, at 1:05 p.m. a progress note indicated the Associated Clinic of Psychology (ACP) notes from 7/27/21, were reviewed. R1 mentioned he has been having difficulty swallowing. Request for a referral to SLP emailed

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2 940	Continued From page 12 to rehab manager and transitional care unit nurse manager (TCU NM) . On 8/24/21, at 12:02 p.m. the assistant director of nursing (ADON) was interviewed. The ADON stated he submitted the referral for a swallow evaluation to be completed to the health unit coordinator (HUC) and was unable to confirm or explain why R1 had not had a been scheduled for swallow evaluation, even though it was noted in R1's care plan on 5/21/21. On 8/24/21, at 12:56 p.m. the registered dietitian (RD)-A was interviewed. RD-A stated she was able to meet with R1 once related to his pressure ulcers, and she had made the recommendation of Mighty Shakes for increased protein intake, which would benefit R1 in the healing process of his wounds. RD-A stated prior to her visit, R1 was not receiving Mighty Shakes as she had wanted to trial it first to see if R1 would be able to keep it down due to his nausea. RD-A also confirmed the Mighty Shakes had been ordered since R1's admission on 5/20/21. On 8/24/21, at 1:17 p.m. SP-A was interviewed and stated R1 had been referred to ST, but on 5/21/21, there was not a "concrete" referral, and and she only started working with R1 on 7/30/21. SP-A stated when she saw R1 on 8/11/21, he was agreeable to going into the hospital to conduct the swallow evaluation. ST-A stated this was supposed to be scheduled, however, facility documentation lacked evidence of scheduling attempts. The facility policy titled Nutritional Status Management dated 4/2/18, directed it is important to maintain adequate nutritional status, to the extent possible, to ensure each resident is sable	2 940		

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2 940	Continued From page 13 to maintain the highest practicable level of well-being. The early identification of residents with, or at risk for, impaired nutrition or hydration status may allow the interdisciplinary team to develop and implement interventions to stabilize or improve nutritional status before complications arise. Body weight and laboratory results can often be stabilized or improved with time but may not be correctable in some individuals. Intake alone, is not the only factor that can affect nutritional status. Resident conditions and co-morbidities may prevent improved nutritional or hydration status, despite improved intake. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for swallowing difficulties and nutritional problems to assure they are receiving the necessary treatment/services to prevent pain during swallowing and weight loss. The director of nursing or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pain during swallowing and weight loss to promote wound healing. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 940		