DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 11, 2025

Administrator
THE VILLAS AT BROOKVIEW

7505 COUNTRY CLUB DRIVE
GOLDEN VALLEY, MN 55427

Re: Reinspection Results
Event ID: 1Y7011

Dear Administrator:

On August 5, 2025 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 June 18, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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September 11, 2025

Administrator
THE VILLAS AT BROOKVIEW
7505 COUNTRY CLUB DRIVE
GOLDEN VALLEY, MN 55427

RE: CCN: 245186
Cycle Start Date: June 18, 2025

Dear Administrator:

On July 24, 2025, we notified you a remedy was imposed. On August 5, 2025, the Minnesota Departments of Health and Public Safety 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 August 25, 2025.

As authorized by CMS the remedy of:

- **Mandatory denial of payment for new Medicare and Medicaid admissions effective September 18, 2025 did not go into effect. (42 CFR 488.417 (b))**

In our letter of July 24, 2025, 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 18, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 25, 2025, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Compliance Analyst | Federal Enforcement

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2025

Administrator
THE VILLAS AT BROOKVIEW
7505 COUNTRY CLUB DRIVE
GOLDEN VALLEY, MN 55427

RE: CCN: 245186
Cycle Start Date: June 18, 2025

Dear Administrator:

On July 24, 2025, we informed you of imposed enforcement remedies.

On August 5, 2025, the Minnesota Department of Health completed a revisit and it has been determined that your facility is not in substantial compliance.

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

The deficiency not corrected is: F658

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 listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 18, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 18, 2025. They will also notify the State

Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 18, 2025.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 $13,343, 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 18, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, THE VILLAS AT BROOKVIEW will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 18, 2025. 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" and/or an "E"tag), i.e., the plan of correction should be directed to:

Supervisor signature block goes here

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 December 18, 2025 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.

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
202-795-7490

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 Steven

Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427

(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
F0000	INITIAL COMMENTS On 6/16/25, 6/17/25, & 6/18/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed: H51866089C (MN00113468), with deficiencies cited at F580, F658, F684, & F842. 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.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F0580	R3's MD updated on deterioration of wound. MD updated for all residents with wounds noted to be deteriorating. To prevent recurrence education completed with licensed nurses on notification of MD when deterioration of wound is noted. Director of Nursing/designee will complete weekly audits to ensure MD is updated on all wounds identified as deteriorating. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	07/28/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

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F0580 SS = D	Continued from page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to notify a resident's physician of the deterioration of a non-pressure related skin wound for 1 of 3 residents (R3) reviewed for non-pressure related skin wounds. Findings include:	F0580		

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F0580 SS = D	Continued from page 2 R3's annual Minimum Data Set (MDS) assessment dated 5/23/25, indicated he admitted to the facility with 6/7/24 and had diagnoses including non-pressure chronic ulcer of left heel and midfoot, morbid obesity, chronic respiratory failure, difficulty in walking, and diabetes mellitus (type 2 diabetes). R3 had diabetic foot ulcer(s) and treatments included application of dressings to feet. R3's care plan dated 6/7/25, identified he had diabetes. Interventions included check all of body for breaks in skin per protocol and treat promptly as ordered by doctor. The care plan identified an actual impairment in skin integrity related to diabetes with left heel diabetic ulcer. Interventions included follow facility protocols for treatment of injury, wedge pillow to offload heel, encourage good nutrition and hydration in order to promote healthier skin, and obtain blood work and labs of any open wounds as ordered by physician. R3's wound care provider note dated 5/15/25, identified a left heel diabetic ulcer measuring 3.1 cm long by 1.8 cm wide by 0.2 cm deep with total area of 5.58 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions noted: clean with Vashe (brand of wound cleanser containing hypochlorous acid), pat dry, skin prep, apply Santyl (brand of collagenase ointment used to break down dead tissue in a wound) and calcium alginate (alginate dressing), ABD (ABD pad) and wrap, change three times weekly and as needed. R3's corresponding Skin and Wound Evaluation dated 5/15/25, identified the wound's measurements and the progress was stable. R3's progress note dated 5/16/25, indicated the IDT met and reviewed R3's skin. He had a diabetic [ulcer] to left heel "noted to be stable." He was followed weekly by the wound care provider. Treatment orders changed from Medihoney to Santyl and calcium alginate. Plan of care reviewed and up to date. R3's physician order with start date 5/17/25 and end date 5/23/25, was for diabetic left heel ulcer treatment and directed clean with wound cleanser, pat	F0580		

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F0580 SS = D	Continued from page 3 dry, Santyl, calcium alginate, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. R3's wound care provider note dated 6/12/25, identified a left heel diabetic ulcer measuring 7.3 cm long by 2 cm wide by 0.2 cm deep with total area of 14.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. Notification section indicated R2's primary care physician, medical doctor (MD)-A, was notified, though did not specify what MD-A was notified about. R3's corresponding Skin and Wound Evaluation dated 6/12/25, identified the wound's measurements and the progress was stable. There was 100% granulation tissue, no evidence of infection, moderate serosanguineous drainage, no odor, periwound erythema with normal temperature, no pain, intact dressing, cleansing solution of Vashe, enzymatic debridement, primary dressing of calcium alginate and other (collagen particles, Santyl, ABD pad), and secondary dressing of compression wrap. R3's progress note dated 6/13/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date. R3's physician order with start date 6/17/25, was for diabetic ulcer left heel treatment with the same treatment directions as order dated 5/24/25. The order directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. During an interview on 6/18/25 at 8:25 a.m., licensed practical nurse (LPN)-C was a nurse manager. LPN-C stated nurse managers did wound rounds with the wound care provider and she was part of wound rounds for R3. R3 had a diabetic ulcer on his heel. LPN-C reviewed R3's Skin and Wound Evaluations and corresponding wound photos. LPN-C noted the 6/12/25 photo showed three open areas on R3's heel as compared to one open area in photo dated 5/15/25. R3's skin appeared to be cracking	F0580		

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F0580 SS = D	Continued from page 4 and two more areas had opened up since 5/15/25. LPN-C stated the wound "looks like it is deteriorating." She identified the wound was no longer improving and from evaluations and photos from 5/8/25 through 6/12/25 the wound had increased in size, the periwound area looked worse, and there were more open areas. LPN-C explained she was not an expert, but the wound was "not looking good" and looked "worse than it did last week." LPN-C was not aware of R3's physician, MD-A, having been notified of the deteriorating wound, but thought she may have mentioned it to the nurse practitioner but did not have documentation reflecting this notification. LPN-C confirmed that though the Wound Evaluation dated 6/12/25 indicated MD-A had been notified (of unspecified details), she had not notified MD-A of the wound's deterioration. LPN-C stated for a deteriorating wound the primary provider and wound care providers should be notified and updated treatments orders obtained and entered. LPN-C confirmed she did not see any documentation that R3's primary providers were updated about the wound's deterioration and did not see any indication the treatment or plan of care had changed since the new orders from the wound care provider a month ago. During an observation and interview on 6/18/25 at 9:29 a.m., LPN-C removed the dressing dated 6/17/25 from R3's left foot. The ABD pad had serosanguinous drainage present that had gone through the alginate dressing underneath it. Three open areas were observed on R3's foot. LPN-C noted the largest and original open area looked "worse" and "bigger" than it had last week and it had grown in length and was almost connected to the newer smaller open area present beneath it. LPN-C stated she was going to call and notify the provider and see what they wanted to do for treatment because maybe the current treatment wasn't working. During an interview on 6/18/25 at 11:05 a.m., nurse manager registered nurse (RN)-C stated she would wait roughly a week or two weeks to determine if a treatment was working or a wound was deteriorating. If a wound was worsening in progress, the primary provider and wound care providers should be notified. During an interview on 6/18/25 at 11:05 a.m., the director of nursing (DON) stated for a wound that was deteriorating both the wound care provider and primary care provider should be updated. If a wound was deteriorating staff needed to have a conversation with the provider and try to do a root cause analysis to see	F0580		

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F0580 SS = D	Continued from page 5 why it was deteriorating. During an interview on 6/18/25 at 10:14 a.m., nurse practitioner (NP)-B stated she was covering for MD-A's usual nurse practitioner. NP-B stated she had not been notified of R3's worsening diabetic left foot ulcer wound and would review documentation for indication that MD-A or the other nurse practitioner had been notified .... In a continued interview at 12:38 p.m., NP-B stated she did not see any documentation that the facility had notified R3's primary care team of his wound deteriorating. NP-B confirmed she would expect the primary care team to be notified of a wound increasing in size or new open areas. NP-B stated this was important because they may want to draw labs, make sure there was no osteomyelitis (bone infection), see what could be precipitating the issue of wound healing, or see what else they could do. NP-B stated notification should be made and documented. Facility policy titled Notification of Changes Policy dated 3/2024, included "It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician) ... The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment and preferences to address the changes."	F0580		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F0658	R1’s MD updated for clarification of wound treatment orders and orders transcribed. R2’s treatment orders from appointment transcribed with wound improvements noted. Wound NP updated for current wounds in house with correct wound treatments in place.	07/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

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THE VILLAS AT BROOKVIEW	7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427

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F0658 SS = D	Continued from page 6 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure professional standards of practice for treatment orders were followed for 2 of 3 residents (R1, R2) reviewed for non-pressure related skin wounds who had wound care orders which were not transcribed. Findings include: R1 R1's admission Minimum Data Set (MDS) assessment dated 5/19/25, indicated she admitted to the facility on 5/13/25 with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R1 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment. R1's Skin Evaluation and Skin Risk Factors assessment dated 5/14/25, identified she had a surgical incision on her coccyx (tail bone) with treatment of a wound vacuum-assisted closure (VAC, a negative pressure wound therapy (NPWT) that applies suction via Granufoam, a foam dressing, applied to the wound bed connected to a portable vacuum pump with a drainage tube that removes fluid draining from the wound). R1's care plan dated 5/14/25, identified she had an alteration in skin integrity with right gluteal surgical wound with a wound VAC. Interventions included treatment to open areas per order. R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness. R1's hospital consult note from wound, ostomy, and continence (WOC) nursing services dated 5/27/25, indicated WOC was consulted for right buttock wound. The note identified a surgical wound to right buttock with negative pressure wound therapy. The note also	F0658	Continued from page 6 To prevent recurrence education to licensed nurses completed on transcription of wound treatments upon admission and after appointments. Director of Nursing/designee will complete weekly audits to ensure wound treatments are transcribed upon admission and return from appointments. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

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F0658 SS = D	Continued from page 7 identified a suction injury wound to right buttock towards hip with contributing factor of "Granufoam to good tissue without drape [a transparent adhesive film-like acrylic and silicone dressing] placed." The note identified R1 admitted to the hospital on 5/24/25 with the wound VAC remining in place since her admission. It was removed "revealing significant suction burn from Granufoam bridge being in direct contact with good tissue." R1's hospital consult note from WOC nursing services dated 5/30/25, indicated the periwound area had mild improvement and the wound VAC could be resumed upon R1's discharge from the hospital. The nurse "discussed importance of protecting periwound from black sponge" and "placed discharge order." R1's hospital progress nursing note dated 5/30/25, indicated the nurse gave report to a registered nurse (RN) at the facility and updated the RN on the wound vac orders. R1's hospital discharge summary dated 5/30/25, included discharge procedure orders for wound care. The orders noted a wound VAC was in place on the right gluteal area. A wound care order for the right buttock included "Daily dressing changes with Vashe (a wound cleanser) packing done inpatient due to periwound damage from black foam being placed directly to skin prior to admission. OK to resume NPWT at discharge. Please protect periwound skin with transparent drape under any foam when bridging [using extra pieces of foam to create a connection point to the VAC device other than to the foam applied directly to the wound, often to adjust positioning of the drainage tube] SensaTRAC pad [pad on the end of the drainage tube that connects from the VAC device to the foam dressing to provide drainage and suction]." This was followed by specific wound VAC dressing change orders for Mondays, Wednesdays, and Fridays of "Wash hands and apply non-sterile gloves. To prevent reflux from tubing, close clamp. Turn off VAC pump. Remove old dressing. If adhered to wound base, moisten old foam with normal saline for 5-10 minutes. Cleanse wound bed with wound cleanser to remove debris. Ensure all foam is removed. Examine wound bed: drainage, tunneling, undermining, size. Check condition of periwound skin. Cleanse periwound skin with wound cleanser and pat dry. Prep wound margins with skin protectant. Add window paining to wound edges with transparent drape. Apply alginate AG [alginate dressing, an absorbent wicking antimicrobial pad] to	F0658		

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F0658 SS = D	Continued from page 8 periwound wound bed. Add strip of transparent drape where bridging will be applied. This will hold alginate AG in place. Cut and shape black granulofoam to fit the size and shape of the wound. Do not cut over wound bed. Place shaped foam into wound bed. Cut strip of black granulofoam for bridging onto hip and apply over top of existing transparent drape. The 2 pieces of foam need to touch. Cut and apply transparent drape material to cover all the foam and wound. The drape material should extend out onto the periwound about a half inch all around. When working with the KCI drape [brand of drape dressing], follow the numbers for ease of application. Start with removing layer #1. Cut 2 cm [centimeter] (quarter) sized hole in drape above foam at end of bridge. Apply over the hole in the drape the SensaTRAC pad with tubing arranged in a direction and position that is comfortable for the patient and avoids excessive pressure against skin. Connect tubing from dressing to tubing coming from VAC suction canister. The connectors lock together. Activate VAC suction unit and check for airleak. Set therapy to physician's prescription. When suction is applied, the foam will contract to a raisin-like appearance. Label dressing with date, time, initial, and number of foam pieces placed in wound." R1's progress note dated 5/30/25, indicated R1 returned to the facility from the hospital. R1's physician orders with start date 5/30/25, in the electronic health record (EHR) included: monitor the wound VAC's collection canister every shift and change as needed; treatment to right buttock surgical wound of continue wound VAC, change Monday and Thursday, suction on 125 mm HG; monitor wound VAC for signs and symptoms of infection around wound VAC site and update provider as needed; and monitor function of wound VAC every shift and update provider as needed. R1's orders did not include the specific discharge procedure wound care orders, including step-by-step instructions for dressing changes on Mondays/Wednesdays/Fridays and application of alginate dressing, placed upon her discharge from the hospital. R1's record lacked evidence the hospital wound care orders were transcribed into the facility's EHR physician orders. During an interview on 6/16/25 at 1:54 p.m., licensed practical nurse (LPN)-A stated orders were usually	F0658		

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F0658 SS = D	Continued from page 9 faxed to the facility prior to a resident admitting, entered ahead of time, and confirmed by the nurse admitting the resident. The admitting nurse would look to make sure all the medications and treatments were correct based on the transfer orders that arrived with the resident, orders were double checked by another nurse, and checked again the next day by a nurse manager. On 6/16/25 at 2:37 p.m., R1 was observed in her bed. LPN-A identified R1's wound on her right buttock/hip with dressing she had changed earlier that day. R1's surgical wound had foam inside of it and a piece of bridge foam extending from the foam in the wound off to the right side which was connected to the drainage tubing and wound VAC. On the upper right side of the surgical wound there was an area of redness extending diagonally approximately three inches identified as LPN-A as the area where it looked like bridge foam had been previously placed without a drape underneath it. LPN-A confirmed the dressing did not include notation of the date or time it was changed, her initials as the person who changed it, or indicate how many pieces of foam were used to fill the wound bed in accordance with the hospital wound care orders. In a follow-up interview at 3:44 p.m., LPN-A confirmed she had not been applying and had not applied an alginate dressing underneath the bridge foam and did not see any present during the earlier observation of R1's dressing. During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound care orders came from her hospital discharge paperwork and the current order dated 5/30/25 was to change the wound VAC dressing Mondays and Thursdays with suction at 125 mm Hg. RN-C was unaware of the detailed wound care orders from R1's hospital discharge on 5/30/25. She noted the orders had been faxed to the facility prior to R1's arrival and uploaded in her EHR, but RN-C had never seen them before. RN-C had talked to the hospital who said they would send specific orders on how to protect R1's periwound area, but the orders R1 arrived with from the hospital did not include this. RN-C was not aware of any follow-up done regarding the orders. RN-C confirmed the orders were not transcribed into the EHR, R1's wound care had not been in accordance with the physician orders, and she would expect the detailed wound care orders to be followed. During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated treatment	F0658		

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F0658 SS = D	Continued from page 10 orders from the hospital should be followed for any alterations in skin integrity when a resident is admitted. The DON confirmed treatments should be in accordance with provider orders which should be transcribed into residents' EHRs after review by two nurses. The DON stated orders should be transcribed and not doing so might lead to the wrong treatment being done or deterioration of a wound. If orders were absent from the medical record, then the continuous plan of care for a resident would be disrupted. During an interview on 6/18/25 at 9:41 a.m., nurse practitioner (NP)-A stated she worked with the surgical team and had seen R1 for a follow-up appointment on 5/22/25 with another follow-up appointment next week. NP-A stated members of the surgical team had seen R1 during her recent hospitalization from 5/24/25 through 5/30/25 and placed the discharge wound care orders. NP-A stated she would expect orders that are included in discharge instructions to be transcribed and followed. NP-A stated the surgical team's intention was for R1's discharge wound care orders to be followed until she came back in for her follow-up appointment. NP-A noted potential outcomes of not following the orders included maceration and worsening of the suction burn injury, denuding and erosion of the periwound area, a delay in healing, or worsening of the wound. R2 R2's MDS assessment dated 6/8/25, indicated she admitted to the facility on 5/22/25 with recent re-entry on 6/2/25 from the hospital. R2 had diagnoses including other fracture and mechanical complication of internal right hip prosthesis (problem with an artificial hip joint). R2 had orthopedic surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle during the prior inpatient hospital stay requiring active care at the facility and a surgical wound. R2's care plan dated 5/23/25, identified she had an alteration in skin integrity related to surgical intervention with surgical wound to hip. Interventions included treatment to open areas per order. R2's physician orders dated 6/2/24, included: monitor surgical incision site for signs and symptoms of infection and healing every shift; and do not apply	F0658		

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F0658 SS = D	Continued from page 11 creams, lotions, powder, or hydrogen peroxide to the incision. R2's progress note dated 6/4/25, indicated a call was received from R2's orthopedic clinic who would be at the facility that day to see R2. The provider ordered an x-ray to be done at the facility prior to the appointment. R2's Orthopedic Progress Note and Provider Orders document dated 6/4/25, indicated R2 was seen that day for three to five week post-operative visit following a right femur fracture with revision femoral implant (fracture of the thigh bone near a hip replacement implant requiring revision surgery to replace the original implant). Orders included "Wound care: incision looks good, sutures were removed. Steri Strips to fall off on their own. Ok for incision to get wet in the shower." R2's progress note dated 6/6/25, indicated the interdisciplinary team (IDT) met to review R2's skin and wound, she admitted with a surgical incision to right hip. The surgical non-removable dressing was removed by orthopedics with Steri-Strips (brand of thin adhesive bandages used to close incisions) in place. Incision clean, dry, and intact with treatment orders in place. The care plan was reviewed and up to date. R2's physician orders did not include the wound care order from R2's orthopedic follow-up appointment on 6/4/25. On 6/17/25 at 9:48 a.m., R2's right hip surgical incision was observed while she was lying in bed. The incision extended down R2's outer thigh from her hip and had Steri-Strips in place near the middle portion of the incision line. Nurse manager, RN-C, stated the incision appeared approximately 16 inches long and there were four Steri-Strips present across the incision line which appeared to be closed. During an interview on 6/17/25 at 10:00 a.m., nurse manager RN-C stated R2 had admitted with a right hip surgical incision. RN-C stated R2's current wound care orders were "just the monitoring." RN-C noted orthopedics came out to see R2 on 6/4/25 at the facility. Upon review of the Orthopedic Progress Note	F0658		

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F0658 SS = D	Continued from page 12 and Provider Orders document dated 6/4/25, RN-C stated the wound care orders were that Steri-Strips had been placed, okay for Steri-Strips to fall off on their own, and okay for incision to get wet in the shower. RN-C confirmed these wound care orders were not present in the physician orders in R2's EHR and should have been transcribed. RN-C stated the note was in R2's paper chart, but the orders had note been transcribed into the EHR. During a follow-up interview on 6/18/25 at 10:41 a.m., RN-C noted that if the order was not transcribed there was the potential for staff to remove the Steri-Strips which could result in wound dehiscence. RN-C confirmed the standard of practice was to transcribe physician orders and provide treatment accordingly. During an interview on 6/17/25 at 12:20 p.m., the DON stated the facility was looking into transcription of orders and reviewing charts to make sure they caught all post-appointment orders and transcribed them. During a follow-up interview on 6/18/25 at 11:05 a.m., the DON stated wound treatments should be done in accordance with provider orders and orders should be transcribed into the chart. If orders were not transcribed and a nurse saw that a resident had a wound, they should review the electronic and paper charts to review the orders present and communicate to the provider if orders were missed. Facility policy titled Skin Assessment & Wound Management dated 2/2025, indicated for ongoing skin issues staff were to follow ongoing treatments per provider order. Facility policy titled Medication and Treatment Orders dated 2/2024, included a policy statement of "Orders for medications and treatments will be consistent with principles of safe and effective order writing." Implementation included, "Orders for medications and treatments will be transcribed accurately and in a timely fashion."	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a	F0684	R1 had comprehensive wound care assessment completed with noted improvement to wounds. R1’s wound treatment clarified and transcribed for accurate wound treatments. R2 had comprehensive wound assessment completed. MD updated on deterioration of R3’s wound with wound treatments transcribed. All residents with active wounds have comprehensive	07/28/2025

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F0684 SS = D	Continued from page 13 resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess non-pressure related skin wounds for 2 of 3 residents (R1, R2) reviewed for non-pressure related skin wounds. In addition, the facility failed to administer non-pressure related skin wound treatments in accordance with physician orders for 1 of 3 residents (R1) and failed to identify deterioration of a non-pressure related skin wound for 1 of 3 residents (R3) reviewed for non-pressure related skin wounds. Findings include: R1 R1's Minimum Data Set (MDS) assessment dated 5/19/25, indicated she admitted to the facility on 5/13/25 with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R3 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment. R3 was cognitively intact. R1's Skin Evaluation and Skin Risk Factors assessment dated 5/14/25, identified she had a surgical incision on her coccyx (tail bone) with treatment of a wound vacuum-assisted closure (VAC, a negative pressure wound therapy (NPWT) that applies suction via Granufoam, a foam dressing, applied to the wound bed connected to a portable vacuum pump with a drainage tube that removes fluid draining from the wound). R1's care plan dated 5/14/25, identified she had an alteration in skin integrity with right gluteal surgical wound with a wound VAC. Interventions included treatment to open areas per order, weekly measurement and assessment of wound, monitor for skin breakdown and signs/symptoms of infection and report to providers, document on skin condition and keep providers informed	F0684	Continued from page 13 wound assessments completed. MD updated for all residents with wounds noted to be deteriorating. Wound NP updated for current wounds in house with correct wound treatments in place. To prevent recurrence education to licensed nurses completed on transcription of wound treatments upon admission and after appointments, updating MD when deterioration of wound is noted completed. Education to nurse leadership completed to ensure comprehensive wound care assessments completed per facility policy. Director of Nursing/designee will complete weekly audits to ensure wound treatments are transcribed upon admission and return from appointments, comprehensive wound assessments completed per facility policy and documentation of MD notification when wounds are noted to be deteriorating. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F0684 SS = D	Continued from page 14 of changes. R1's physician order with start date 5/14/25 and end date 5/15/25, directed to continue large wound VAC and dressing on right buttock wound, change Monday Wednesday and Friday, suction at 125 millimeters of mercury (mm Hg). R1's medication administration record (MAR) progress note dated 5/14/25, indicated the wound VAC was not changed as staff were waiting for the wound VAC. R1's progress note dated 5/15/25, indicated the wound VAC arrived and was placed on the right gluteal wound, wound provider present and assessed wound at that time. R1's physician order with start date 5/19/25, directed to continue wound VAC on right buttock wound, change Monday and Thursday, suction on 125 mm Hg. R1's surgical clinic follow-up visit note by nurse practitioner (NP)-A dated 5/22/25, indicated R1's wound vac was removed but not able to be replaced as supplies were not sent with her. NP-A placed a wet-to-dry dressing and covered with an abdominal pad (ABD pad, an absorbent gauze dressing). Orders included change wound vac dressing on Monday, Wednesday, and Friday, "do not place sponge on top of healthy skin," cut foam to fit inside wound, and call if questions. R1's MAR dated 5/1/25 through 5/31/25, indicated wound VAC dressing changes were completed on 5/19/25 and 5/22/25. R1's progress note dated 5/23/25 at 10:50 a.m., indicated the wound VAC alarm went off at 6:30 a.m. Licensed practical nurse (LPN)-A found that the wound VAC device had failed and was unable to be reset, called the facility's medical supply company to obtain a replacement wound VAC, and was awaiting delivery. LPN-A removed the wound VAC dressing and replaced it with a wet-to-dry dressing until the new wound VAC could be applied, updated the resident, and updated the nurse manager. The progress note did not indicate the provider was contacted to notify of the wound VAC failure or obtain a new order for a wet-to-dry dressing.	F0684		

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F0684 SS = D	Continued from page 15 R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness. R1's hospital consult note from wound, ostomy, and continence (WOC) nursing services dated 5/27/25, indicated WOC was consulted for right buttock wound. The note identified a surgical wound to right buttock with negative pressure wound therapy (wound VAC). The note also identified a suction injury wound to right buttock towards hip with contributing factor of "Granufoam to good tissue without drape [a transparent adhesive film-like acrylic and silicone dressing] placed." The note identified R1 admitted to the hospital on 5/24/25 with the wound VAC remining in place since her admission. It was removed "revealing significant suction burn from Granufoam bridge being in direct contact with good tissue." R1 experienced "significant pain" with the dressing change and the plan was to take a break from the wound VAC to allow the periwound area (skin surrounding a wound, where the suction burn was located) to heal. R1's hospital consult note from WOC nursing services dated 5/30/25, indicated the periwound area had mild improvement and the wound VAC could be resumed upon R1's discharge from the hospital. The nurse "discussed importance of protecting periwound from black sponge" and "placed discharge order." The suction injury wound was not measured, had a red wound base, moderate sanguineous (bloody) drainage, with periwound skin erythema (redness), maceration (breakdown and softening of skin due to exposure to excessive moisture), and fragile/thin. R1's hospital discharge summary dated 5/30/25, included discharge procedure orders for wound care. The orders noted a wound VAC was in place on the right gluteal area. A wound care order for the right buttock included "Daily dressing changes with Vashe (a wound cleanser) packing done inpatient due to periwound damage from black foam being placed directly to skin prior to admission. OK to resume NPWT at discharge. Please protect periwound skin with transparent drape under any foam when bridging [using extra pieces of foam to create a connection point to the VAC device other than to the foam applied directly to the wound, often to adjust positioning of the drainage tube] SensaTRAC pad [pad on the end of the drainage tube that connects from	F0684		

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F0684 SS = D	Continued from page 16 the VAC device to the foam dressing to provide drainage and suction]." This was followed by wound VAC dressing change orders to change Mondays, Wednesdays, and Fridays with step-by-step instructions including: Apply alginate AG [alginate dressing, an absorbent wicking antimicrobial pad] to periwound wound bed; add strip of transparent drape where bridging will be applied to hold alginate AG in place; and label dressing with date, time, initial, and number of foam pieces placed in wound. R1's progress note dated 5/30/25, indicated R1 returned to the facility from the hospital. R1's physician orders with start date 5/30/25, in the electronic health record (EHR) included: monitor the wound VAC's collection canister every shift and change as needed; treatment to right buttock surgical wound of continue wound VAC, change Monday and Thursday, suction on 125 mm HG; monitor wound VAC for signs and symptoms of infection around wound VAC site and update provider as needed; and monitor function of wound VAC every shift and update provider as needed. R1's orders did not include the hospital discharge wound care orders, including step-by-step instructions for dressing changes on Mondays/Wednesdays/Fridays and application of alginate dressing. R1's MAR dated 5/30/25 through 6/16/25, indicated the treatment order for right buttock surgical wound to continue wound VAC, change Monday and Thursday, suction on 125 mm HG was completed on 6/2/25, 6/5/25, 6/9/25, 6/12/25, and 6/16/25. R1's MAR lacked evidence that wound treatment was completed in accordance with the hospital discharge wound care orders dated 5/30/25. R1's Admission/Initial Data Collection assessment dated 5/30/25, included a skin section with area to identify alterations in skin integrity and the associated site, type, length, width, depth, and stage (if alteration was pressure-related). No alterations in skin integrity were identified. Comments included "healing skin alteration on right hip" and wound on right buttock with dressing dry and intact. The assessment lacked any further information about the new suction injury wound and did not include a comprehensive assessment of the injury.	F0684		

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F0684 SS = D	Continued from page 17 R1's Skin Evaluation and Skin Risk Factors assessment dated 5/31/25, included a current skin issues section including description of wound bed for each site, description of drainage amount and odor, description of periwound area, and current treatment. This section was blank. Question "are there any new wound[s] prompting assessment?" was marked "no." The risk factors and interventions sections were blank. The summary noted she readmitted with "new skin to periwound of buttock wound," wound VAC placed, skin prep to periwound, and wound provider to see resident next week. The assessment lacked any further information about the new suction injury wound and did not include a comprehensive assessment of the injury. R1's Weekly Skin Inspection assessment dated 6/5/25, included a summary of current skin condition with note that wound VAC was on. R1's Wound Care note dated 6/5/25, indicated R1 was seen by the wound care provider regarding surgical wound to right gluteal area. The note indicated the wound was improving with "no new area of concern." One wound was identified, a surgical right gluteal wound 7.7 cm long x 4.4 cm wide x 5.3 cm deep with moderate serosanguineous (mix of bloody and clear) exudate (drainage), identification of tissue type, periwound area positive for erythema, and note "moderate erythema." Treatment plan was continue wound VAC as ordered. The note did not identify the presence of a second wound, the suction burn injury, or include a comprehensive assessment of the wound. R1's Wound Evaluation dated 6/5/25, identified a surgical wound to right gluteus with healing ridge, other closure method, and stable progress with measurements identified in the Wound Care note from the same day. The wound bed, periwound, and treatments sections were blank. It did not identify or include a comprehensive assessment of the suction burn injury wound. R1's Weekly Skin Inspection dated 6/12/25, included a summary of current skin condition with note "no new skin issues noted." R1's Wound Care note dated 6/12/25, indicated R1 was	F0684		

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F0684 SS = D	Continued from page 18 seen by the wound care provider regarding surgical wound to right gluteal area. The note indicated the wound was improving with "no new area of concern." One wound was identified, a surgical right gluteal wound 4.9 cm long x 3 cm wide x 4.5 cm deep with moderate serosanguineous (mix of bloody and clear) exudate (drainage), identification of tissue type, periwound area positive for erythema, and note "mild erythema." Treatment plan was continue wound VAC as ordered. The note did not identify the presence of a second wound, the suction burn injury, or include a comprehensive assessment of the wound. R1's Wound Evaluation dated 6/12/25, identified a surgical wound to right gluteus with healing ridge, other closure method, and improving progress with the measurements identified in the Wound Care note from the same day. Wound bed section identified tissue types and no evidence of infection. Periwound surrounding tissue was erythema with normal temperature. Pain level was zero. Treatment was intact dressing with generic wound cleanser and primary dressing of NPWT. It did not identify or include a comprehensive assessment of the suction burn injury wound. R1's record did not include a comprehensive assessment of the suction burn injury wound on her right gluteus/hip after she re-admitted to the facility on 5/30/25. During an interview on 6/16/25 at 12:38 pm., R1 stated she was at the facility for a wound on her right hip which was connected to a pump (wound VAC) and couldn't go home until it healed up enough that she no longer needed it. R1 stated her dressing was changed every three days. Only a couple of nurses including LPN-A did these dressing changes, and once in a while the dressing would not be right resulting in a leak causing the wound VAC to alarm. R1 noted the wound provider saw her weekly and said the wound was getting better. R1 noted she had to go back to the hospital for a few days after she admitted to the facility, but didn't remember why. During an interview on 6/16/25 at 1:54 p.m., licensed practical nurse (LPN)-A stated she was the charge nurse for R1's unit. LPN-A noted residents had head-to-toe skin assessments completed by a nurse on admission. The next day a nurse manager or charge nurse would do another skin assessment and wound assessments. Wound	F0684		

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F0684 SS = D	Continued from page 19 assessments were then done by the wound care provider during weekly rounds. LPN-A looked in orders to know what to do for a wound including dressings and treatments. If a wound VAC failed there should be an order for an as needed wet-to-dry dressing to use instead. LPN-A noted R1's wound VAC failed on 5/23/25 and she changed the dressing to a wet-to-dry dressing. LPN-A stated she had notified the provider and been instructed to place a wet-to-dry dressing while waiting for a new wound VAC. LPN-A was not sure if R1 had the order for this or if she charted this, but she would have charted the dressing change as an as needed order and charted provider notification in a progress note. LPN-A stated she changed R1's wound VAC a couple of times, always placed a drape down beneath the bridge foam to protect intact skin, and had never seen the bridge foam in direct contact with R1's skin, though knew it had happened because R1 now had a new area of red skin. During an interview on 6/18/25 at 11:50 a.m., registered nurse (RN)-D stated she had changed R1's wound VAC dressing on the morning on 5/24/25 before R1 went to the hospital. RN-D stated R1's wound VAC had failed earlier and she had to take out the wet-to-dry dressing and put the new dressing and wound VAC on that morning. RN-D stated she placed the barrier film (drape) on top of the bridge foam and "didn't put a barrier on the bottom," and the hospital said it "ate" R1's skin. RN-D stated R1 had left for the hospital with the dressing she had applied and new wound VAC in place. RN-D stated she had not been familiar with using a foam bridge with wound VAC dressings and "wasn't sure" at the time if there was supposed to be a barrier underneath it. She proceeded the way she was trained to do for wound VACs without a bridge piece and had not sought clarification. During an observation and interview on 6/16/25 at 2:37 p.m., R1 was observed in her bed. LPN-A identified R1's wound on her right buttock/hip with dressing she had changed earlier that day. R1's surgical wound had foam inside of it and a piece of bridge foam extending from the foam in the wound off to the right side which was connected to the drainage tubing and wound VAC, all covered with transparent drape dressings. Due to the overlapping nature of the transparent film drape dressing pieces underneath and over the foam, the drape under the bridge foam could not be specifically visualized, though LPN-A stated she had applied it. On the upper right side of the surgical wound was an area of redness extending diagonally approximately three	F0684		

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F0684 SS = D	Continued from page 20 inches identified by LPN-A as the area where the bridge foam had been previously placed without a drape underneath. LPN-A confirmed the dressing did not include initials, date, time, or number of pieces of foam used in accordance with the hospital wound care orders. In a follow-up interview at 3:44 p.m., LPN-A confirmed she did not apply an alginate dressing underneath the bridge foam when she had changed the dressing earlier that day. During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound should be monitored every shift with a monitoring order nurses sign off on. RN-C confirmed wound monitoring orders were in place starting 5/30/25, but there was no order for or documentation of wound monitoring every shift from 5/13/25 to 5/24/25 prior to R1's hospitalization. RN-C noted R1's wound VAC malfunctioned on 5/23/25 and a wet-to-dry dressing applied. She expected the provider to be notified of the failure, new order obtained, and documented in a progress note. RN-C confirmed R1's record lacked an order for the wet-to-dry dressing and documentation of provider notification. RN-C stated there were issues with R1's wound vac dressing when she went to the hospital 5/24/25. The bridge was applied improperly resulting in periwound skin damage. RN-C identified R1's wound care orders came from her hospital discharge paperwork and the current order dated 5/30/25 was to change the wound VAC dressing Mondays and Thursdays with suction at 125 mm Hg. RN-C was unaware of the detailed wound care orders from R1's hospital discharge on 5/30/25. She noted the orders had been faxed to the facility prior to R1's arrival, uploaded in her EHR, but RN-C had never seen them before. RN-C stated R1's wound VAC dressing changes were done on Mondays and Thursdays in accordance with direction from the facility's wound care provider but did not see any orders in his notes directing staff to change the treatment from what the hospital ordered. RN-C confirmed R1's wound care had not been in accordance with the physician orders, and she would expect the detailed wound care orders to be followed. During a follow-up interview on 6/17/25 at 10:58 a.m., RN-C stated the suction burn wound was considered part of the peri-wound area of the surgical wound per the wound care provider and confirmed separate wound assessments had not been completed for R1's suction burn wound. RN-C confirmed the surgical wound assessments only identified peri-wound erythema and did not include identification of the suction burn wound's etiology, treatment, measurements, or other details. She did not see assessment of the wound in the wound care provider's weekly notes or photographs that	F0684		

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F0684 SS = D	Continued from page 21 captured the entirety of the wound. RN-C was unable to identify completion of a comprehensive assessment of the suction burn wound. During an interview on 6/16/25 at 1:16 p.m., RN-B stated when residents were admitted nurses did skin assessments immediately and checked for any wounds. Wounds were assessed when doing dressing changes and with weekly skin assessments. Wound care orders were on the MAR and treatments were documented on the MAR. RN-B stated wound VAC dressings had to have a film dressing underneath bridging foam if it was used to avoid skin irritation around the wound. If a wound VAC needed to be changed but supplies were not available, she would call the provider, let them know, and get an order for a different dressing. During an interview on 6/16/25 at 1:00 p.m., RN-A stated nurses did wound care based on physician orders in the MAR, including procedures and dressings. Everything was put in the MAR unless there was a new admit and then "you use the discharge orders." Treatments were charted in the MAR. Wound assessments were completed by nurse managers on admission, by nurses when doing dressing changes, and by the wound care provider who came once weekly. RN-A stated for wound VAC dressing changes, you had to put down a protective barrier over the skin before placing the bridging foam to protect the good skin because it could create a new wound from all the moisture passing through the foam. RN-A noted nurse managers performed wound VAC dressing changes. If a dressing change was needed but supplies were unavailable, RN-A would notify the provider and get an order for a different dressing while waiting for supplies. During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated all wounds were to be comprehensively assessed on admission and at least weekly thereafter. A comprehensive assessment included how the wound looks, drainage, wound bed description and size, the treatments, description of the wound bed and periwound area, presence of tunneling or maceration, wound status of improving deteriorating or stable, and pain. He expected all components of the facility's wound assessments to be completed as part of a comprehensive assessment. On admission, treatment orders from the hospital should be followed for any alterations in skin integrity. The DON confirmed treatments should be in accordance with provider orders. Treatments should be documented and if anything	F0684		

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F0684 SS = D	Continued from page 22 was not done per orders or if orders were missing, nurses should notify the provider. He would expect the provider to be called if a wound VAC failed to notify them of the failure and get an order for a new treatment. The DON confirmed R1's wound vac had not been applied properly with a barrier between the bridge foam and intact skin leading to skin breakdown. During an interview on 6/18/25 at 9:41 a.m., NP-A stated she was part of the surgical clinic team and had seen R1 for a surgical follow-up appointment on 5/22/25 with plan to see her again in a month, but she was re-admitted to the hospital where documentation showed a suction burn injury from the wound VAC. NP-A confirmed R1 was discharged with "specific orders for how to change the wound vac" from the surgical team. NP-A would expect orders that are part of discharge instructions to be transcribed and followed. NP-A stated, "our intention was for these to be followed until she came back in" and noted she did not see evidence that the surgical team had been contacted regarding wound VAC failure, treatment orders, or consultation regarding management of the wound VAC. NP-A noted not following the orders could lead to maceration with the periwound area eroding or denuding which could "delay healing" or "make the wound potentially worse." R2 R2's MDS assessment dated 6/8/25, indicated she admitted to the facility on 5/22/25 with entry on 6/2/25 from the hospital. R2 had diagnoses including other fracture and mechanical complication of internal right hip prosthesis (problem with an artificial hip joint). R2 had orthopedic surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle during the prior inpatient hospital stay requiring active care at the facility and a surgical wound. R2's progress note dated 6/2/25, indicated she re-admitted to the facility following a hospital stay for abdominal distention secondary to an ileus. R2's care plan dated 5/23/25, identified she had an alteration in skin integrity related to surgical intervention with surgical wound to hip. Interventions included: monitor skin integrity daily during cares and weekly skin inspection by nurse, treatment to open	F0684		

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F0684 SS = D	Continued from page 23 areas per order, weekly measurements and assessment of wound, and document on skin condition and keep provider informed of changes. R2's physician orders dated 6/2/24, included: monitor surgical incision site for signs and symptoms of infection and healing every shift; and do not apply creams, lotions, powder, or hydrogen peroxide to the incision. R2's Skin Evaluation and Skin Risk Factors assessment dated 6/2/25, identified a surgical incision to right hip with Steri-Strips (brand of thin adhesive bandages used to close incisions) in place. It did not include additional information about the wound or include measurements. R2's Orthopedic Progress Note and Provider Orders document dated 6/4/25, indicated R2 was seen that day for three to five week post-operative visit following a right femur fracture with revision femoral implant (fracture of the thigh bone near a hip replacement implant requiring revision surgery to replace the original implant). Orders included "Wound care: incision looks good, sutures were removed. Steri Strips to fall off on their own. Ok for incision to get wet in the shower." R2's Wound Evaluation dated 6/4/25, identified a front right hip surgical incision with Steri-Strips present on admission. There was no evidence of infection in the wound bed, no exudate or odor, the periwound edges were attached with surrounding tissue normal in color, no induration or edema, normal temperature, and intermittent three out of ten pain. There was no dressing present and the wound was improving. The dimensions section for measurements of the wound was blank. R2's Weekly Skin Inspection dated 6/4/25, noted a shower was completed and R2 had an incision to right hip. It did not include additional information about the wound or include measurements. R2's Wound Evaluation dated 6/12/25, identified a front right hip surgical incision with Steri-Strips present on admission. It measured 3.73 centimeters (cm) long by 0.47 cm wide. The wound bed, periwound, and treatment	F0684		

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F0684 SS = D	Continued from page 24 sections were blank. The wound's progress was improving with note that "the resident has Steri strips in place healing well staff will continue to monitor wound for changes." On 6/17/25 at 9:48 a.m., R2's right hip surgical incision was observed while she was lying in bed. The incision extended down R2's outer thigh from her hip and had Steri-Strips in place near the middle portion of the incision line. Nurse manager, RN-C, stated the incision appeared approximately 16 inches long, there were four Steri-Strips present across the incision line which appeared to be closed, and the periwound area had dry skin and looked healthy. During an interview on 6/17/25 at 10:00 a.m., nurse manager RN-C stated she completed R2's Wound Evaluation dated 6/4/25. RN-C confirmed the assessment lacked measurements and she would expect a wound assessment to include measurements. RN-C reviewed R2's Wound Evaluation and attached wound photo dated 6/12/25 and stated the measurements were not accurate because the program that calculated measurements from the photo had only picked up on the small scabbed area remaining in the middle of the incision. RN-C stated the assessment did not identify anything in the wound bed section but should have noted the scab and did not identify anything in the periwound section but she would have put dry flaky skin, edges attached or epithelization with new pink sin. Further, it did not identify if there was evidence of infection, exudate, odor, induration, edema, temperature, or pain. RN-C stated a comprehensive assessment of the wound had not been completed, it should have been done, and the 6/4/25 Wound Evaluation should have included measurements to be comprehensive. R3 R3's MDS assessment dated 5/23/25, indicated he admitted to the facility with 6/7/24 and had diagnoses including non-pressure chronic ulcer of left heel and midfoot, morbid obesity, chronic respiratory failure, difficulty in walking, and diabetes mellitus (type 2 diabetes). R3 had diabetic foot ulcer(s) and treatments included application of dressings to feet. R3's care plan dated 6/7/25, identified he had diabetes. Interventions included check all of body for	F0684		

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F0684 SS = D	Continued from page 25 breaks in skin per protocol and treat promptly as ordered by doctor. The care plan identified an actual impairment in skin integrity related to diabetes with left heel diabetic ulcer. Interventions included follow facility protocols for treatment of injury, wedge pillow to offload heel, encourage good nutrition and hydration in order to promote healthier skin, and obtain blood work and labs of any open wounds as ordered by physician. R3's wound care provider note dated 5/15/25, identified a left heel diabetic ulcer measuring 3.1 cm long by 1.8 cm wide by 0.2 cm deep with total area of 5.58 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions noted: clean with Vashe (brand of wound cleanser containing hypochlorous acid), pat dry, skin prep, apply Santyl (brand of collagenase ointment used to break down dead tissue in a wound) and calcium alginate (alginate dressing), ABD (ABD pad) and wrap, change three times weekly and as needed. R3's corresponding Skin and Wound Evaluation dated 5/15/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, wound pain, and treatments sections were blank. R3's progress note dated 5/16/25, indicated the IDT met and reviewed R3's skin. He had a diabetic [ulcer] to left heel "noted to be stable." He was followed weekly by the wound care provider. Treatment orders changed from Medihoney to Santyl and calcium alginate. Plan of care reviewed and up to date. R3's physician order with start date 5/17/25 and end date 5/23/25, was for diabetic left heel ulcer treatment and directed clean with wound cleanser, pat dry, Santyl, calcium alginate, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. R3's wound care provider note dated 5/22/25, identified a left heel diabetic ulcer measuring 2.6 cm long by 1.6 cm wide by 0.2 cm deep with total area of 4.16 cm squared with progress of improving. Exudate was moderate serosanguineous with 90% granulation and 10% slough tissue and presence of periwound maceration with note mild maceration. Treatment plan was updated and	F0684		

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F0684 SS = D	Continued from page 26 instructions noted: clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate and Santyl, ABD and wrap, change three times weekly and as needed. R3's corresponding Skin and Wound Evaluation dated 5/22/25, identified the wound's measurements and progress was improving. The wound bed, exudate, periwound, wound pain, and treatments sections were blank. R3's progress note dated 5/23/25, indicated the IDT met to review R3's wound. Diabetic ulcer was improving. Wound care provider continued to follow. Current treatment would continue with no new areas of concern. Plan of care was up to date. R3's physician order with start date 5/24/25 and end date 6/16/25, was for diabetic ulcer left heel treatment and directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. R3's wound care provider note dated 5/29/25, identified a left heel diabetic ulcer measuring 3.5 cm long by 1.6 cm wide by 0.2 cm deep with total area of 5.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and no periwound erythema. Treatment instructions were unchanged. R3's corresponding Skin and Wound Evaluation dated 5/29/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, wound pain, and treatment sections were blank. R3's progress noted ate 5/30/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow and current treatment to continue. Plan of care was up to date. R3's wound care provider note dated 6/5/25, identified a left heel diabetic ulcer measuring 6.4 cm long by 1.5 cm wide by 0.2 cm deep with total area of 9.6 cm squared with progress of stable. Exudate was moderate	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245186	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427

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F0684 SS = D	Continued from page 27 serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. R3's corresponding Skin and Wound Evaluation dated 6/5/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, pain, and treatment sections were blank. R3's progress note dated 6/6/25, indicated the IDT met to review R3's wound. Diabetic ulcer was stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date. R3's wound care provider note dated 6/12/25, identified a left heel diabetic ulcer measuring 7.3 cm long by 2 cm wide by 0.2 cm deep with total area of 14.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. R3's corresponding Skin and Wound Evaluation dated 6/12/25, identified the wound's measurements and progress was stable. There was 100% granulation tissue, no evidence of infection, moderate serosanguineous drainage, no odor, periwound erythema with normal temperature, no pain, intact dressing, cleansing solution of Vashe, enzymatic debridement, primary dressing of calcium alginate and other (collagen particles, Santyl, ABD pad), and secondary dressing of compression wrap. R3's progress note dated 6/13/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date. R3's physician order with start date 6/17/25, was for diabetic ulcer left heel treatment with the same treatment directions as order dated 5/24/25. The order directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday.	F0684		

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F0684 SS = D	Continued from page 28 Review of R3's medication and treatment administration records (MAR/TAR) dated months of May and June 2025, identified documentation of treatments completed in accordance with physician orders as scheduled. The ordered treatments were completed on 5/17/25, 5/22/25, 5/24/25, 5/27/25, 5/31/25, 6/3/25, 6/5/25, 6/10/25, 6/12/25, 6/14/25, and 6/17/25. Dressing change on 5/29/25 was documented as not completed, but corresponding MAR progress note dated 5/29/25 indicated it had already been done that day. During an interview on 6/17/25 at 12:25 p.m., LPN-B stated R3 had a diabetic ulcer on his left heel. Treatment was to clean with Vashe and then pat dry, prep the skin, cover with calcium alginate, collagen, Santyl, then apply an ABD pad and wrap it. This dressing was changed three days per week. LPN-B thought the ulcer was getting better because it wasn't draining a lot and was kind of closing up. During an interview on 6/17/25 at 12:35 p.m., R3 stated he had a wound on his left foot that staff would wrap and put some stuff on three days a week. The wound team looked at it on Thursdays. R3 noted LPN-B had changed his dressing earlier that morning. During an interview on 6/18/25 at 8:25 a.m., nurse manager LPN-C stated nurse managers did wound rounds with the wound care provider and she was part of wound rounds for R3. LPN-C stated R3 had a diabetic ulcer on his heel. LPN-C reviewed R3's Skin and Wound Evaluations and corresponding wound photos and noted the measurements were not always correct because of the program used to measure the wounds automatically based on the photos. LPN-C stated she had to manually draw part of the area for measurement on the 6/12/25 assessment and it went past the edge of the wound. LPN-C noted that the 6/12/25 photo showed three open areas on R3's heel as compared to one open area in photo dated 5/15/25. LPN-C stated R3's skin appeared to be cracking and two more areas had opened up since 5/15/25. LPN-C stated the wound "looks like it is deteriorating." LPN-C stated the wound care provider would determine how the wound looked and that's what she would document. She identified the wound was no longer improving and from evaluations and photos from 5/8/25 through 6/12/25 the wound had increased in size, the periwound area looked worse, and there were more open areas. LPN-C did not endorse having previously identified that the wound was worsening, though stated	F0684		

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F0684 SS = D	Continued from page 29 she had manually circled the third open area in the photo dated 6/12/25 because she noticed it was a new spot and let the wound care provider know. LPN-C stated she was sure she mentioned to R3's primary nurse practitioner that his wound care orders had changed, but could not articulate when and how it was identified and addressed that R3's wound was deteriorating. LPN-C noted staff had to wait a few weeks to see if a new treatment was working and give the wound time to heal, and noted it had been a month since R3's orders had changed. LPN-C was unsure of the protocol for the length of time a wound for following a wound before determining that it was not improving and adjusting treatments. LPN-C stated she was not an expert, but the wound was "not looking good" and looked "worse than it did last week." She noted the weekly IDT wound meetings included the nurse managers and R3's wound was documented in IDT progress notes as stable because that is what was in the wound care provider notes. LPN-C noted she did not see any documentation identifying the wound as deteriorating or indication that the treatment or plan of care had changed since the wound care orders were updated a month prior. On 6/18/25 at 9:29 a.m., LPN-C removed the dressing dated 6/17/25 from R3's left foot. The ABD pad had serosanguinous drainage present that had gone through the alginate dressing underneath it. Three open areas were observed on R3's foot. LPN-C noted the largest and original open area looked "worse" and "bigger" than it had last week and it had grown in length and was almost connected to the newer smaller open area present beneath it. LPN-C stated she was going to call and notify the provider and see what they wanted to do for treatment because maybe the current treatment wasn't working. During an interview on 6/18/25 at 10:41 a.m., nurse manager RN-C stated if a wound was deteriorating the dressing (treatment) needed to be changed right away, staff needed to do something different. She would wait roughly a week, maybe two weeks, depending on how often dressing changes were done before determining if a treatment was effective or not. During an interview on 6/18/25 at 11:05 a.m., the DON stated both the wound care provider and primary care provider should be updated if a wound was deteriorating and staff should be constantly updating the provider. The DON stated he was not sure what the specific protocol was at the facility for the time frame was for	F0684		

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F0684 SS = D	Continued from page 30 making a determination about a wound's progress, but standard care was to wait two weeks and if the wound was still deteriorating have a conversation with the provider and try to do a root cause analysis to see why it was deteriorating. Further, the root cause analysis should be done every week at the IDT wound meetings, though he had just started and not yet been present at this meeting. The DON noted signs of wound deterioration included increased exudate, slough in the wound, an increase in eschar, if the area was bigger than it was previously, increase in pain, or new open areas. The DON reviewed R3's wound photos and stated if he saw that he would question the provider and advocate for the resident if it was identified as stable or improving as in the wound's documentation. He would expect a wound increasing in size to be identified in the IDT wound review. Facility policy titled Skin Assessment & Wound Management dated 2/25, included a section for non-pressure wounds and altered skin integrity. The section for a new skin problem included "When a significant alteration in skin integrity is noted; (i.e., large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken: 7. Notify Provider/Treatment Ordered. 8. Notify resident representative. 9. Complete education with resident/resident representative including risks & benefits. 10. Initiate Skin and Wound Evaluation. 11. Notify Nurse Manager/Wound Nurse. 12. Referral to dietary, if appropriate. 13. Referral to therapies, if appropriate. 14.Review and update care plan including interventions. 15.Update resident care lists. 16.Update Care Plan to identify risks for skin breakdown." The section for ongoing skin issues included, "Follow ongoing treatments per provider order. Update provider and resident/representative as needed. Update care plan as needed."	F0684		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the	F0842	R1's wound treatment reviewed and PRN wound treatment currently in place per MD orders. All residents with active wounds reviewed to include PRN wound treatment orders for documentation required outside of scheduled treatments. To prevent recurrence education to all licensed nurses completed on documentation of wound care treatments per MD orders.	07/28/2025

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F0842 SS = D	Continued from page 31 facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or	F0842	Continued from page 31 Director of Nursing/designee will complete weekly audits to completion of wound treatments are documented in resident's medical record. Results will be brought to the QAPI committee monthly to review for continued opportunities for quality improvements.	

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F0842 SS = D	Continued from page 32 (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain complete, accurate, and up-to-date medical records of administered wound care treatments for 1 of 3 residents (R1) reviewed for non-pressure related skin injuries. Findings include: R1's Minimum Data Set (MDS) assessment dated 5/19/25, indicated she admitted to the facility on 5/13/25 with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R1 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment. R1's physician order with start date 5/14/25 and end date 5/15/25, directed to continue large wound VAC and dressing on right buttock wound, change Monday Wednesday and Friday, suction at 125 millimeters of mercury (mm Hg).	F0842		

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F0842 SS = D	Continued from page 33 R1's medication administration records (MAR) progress note dated 5/14/25, indicated the wound VAC was not changed as staff were waiting for the wound VAC. R1's progress note dated 5/15/25, indicated the wound VAC arrived and was placed on the right gluteal wound, wound provider present and assessed wound at that time. R1's physician order with start date 5/19/25, directed to continue wound VAC on right buttock wound, change Monday and Thursday, suction on 125 mm Hg. R1's progress note dated 5/23/25 at 10:50 a.m., indicated the wound VAC alarm went off at 6:30 a.m. Licensed practical nurse (LPN)-A found that the wound VAC device had failed and was unable to be reset, called the facility's medical supply company to obtain a replacement wound VAC, and was awaiting delivery. LPN-A removed the wound VAC dressing and replaced it with a wet-to-dry dressing until the new wound VAC could be applied. R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness. During an interview on 6/16/25 at 1:54 p.m., LPN-A stated R1's wound VAC failed on 5/23/25 and she changed the dressing to a wet-to-dry dressing and was not sure if there was a physician order to do so. However, had there been an order for the wet to dry dressing she would have documented the treatment as complete under the order on the treatment administration record (TAR). LPN-A stated the new wound VAC had not been delivered by the end of her shift on 6/23/25, so another nurse had changed the wet-to-dry dressing back to the wound VAC after it arrived. During an interview on 6/18/25 at 11:50 a.m., registered nurse (RN)-D stated she had worked with R1 when she went to the hospital on 5/24/25 and confirmed R1 left with her wound VAC dressing in place. RN-D stated R1's wound VAC had failed earlier and she had taken out the wet-to-dry dressing and put the new dressing and new wound VAC on that morning before R1 went to the hospital.	F0842		

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F0842 SS = D	Continued from page 34 R1's medication and treatment administration record (MAR/TAR) dated 5/1/25 through 5/31/25, included documented wound VAC dressing changes on the following dates: 5/19/25 and 5/22/25. R1's MAR/TAR lacked documentation of the following wound care treatments: - Wound VAC dressing change on 5/15/25 by wound care provider - Wet-to-dry dressing change on 5/23/25 by LPN-A - Wound VAC dressing change on 5/24/25 by RN-D During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound VAC malfunctioned on 5/23/25 and a wet-to-dry dressing was applied. RN-C confirmed R1's record lacked an order for the wet-to-dry dressing and documentation of the wet-to-dry dressing change on 5/23/25. RN-C stated there were issues with R1's wound vac dressing when she went to the hospital on 5/24/25, but she did not know who had placed the wound VAC dressing because the removal of the wet-to-dry dressing and replacement of the wound VAC dressing was not documented. In a follow-up interview on 6/18/25 at 10:41 a.m., RN-C stated she did not see any documentation that R1's dressing was changed with wound VAC reapplied prior to her hospital transfer on 5/24/25, though remembered R1 leaving with her wound VAC. She would expect this to be documented. RN-C noted that if transferred, a receiving provider would determine when a dressing was last changed based on the MAR/TAR, which wouldn't be correct if the treatments were not documented; medical record accuracy was needed to know what cares had been provided and what needed to be done. RN-C confirmed R1's medical record was not complete or accurate. During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated wound care treatments should be documented in treatment orders (TAR). The DON noted it was important for medical records to be complete and accurate because medical records act as a guide for providing patient care. He "absolutely" expected medical records to be complete and accurate. Facility policy regarding contents of medical records requested but not received.	F0842		

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20000	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 6/16/25, 6/17/25, & 6/18/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaint was reviewed: H51866089C (MN00113468) with licensing orders issued at 0265, 0625, & 0830. 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 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. 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.	20000		
20265	Notification of Chg in Resident Health Status CFR(s): MN Rule 4658.0085 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director	20265	Corrected.	07/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **06/18/2025**

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THE VILLAS AT BROOKVIEW	**7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427**

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20265	Continued from page 2 of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to notify a resident's physician of the deterioration of a non-pressure related skin wound for 1 of 3 residents (R3) reviewed for non-pressure related skin wounds. Findings include: R3's annual Minimum Data Set (MDS) assessment dated 5/23/25, indicated he admitted to the facility with 6/7/24 and had diagnoses including non-pressure chronic ulcer of left heel and midfoot, morbid obesity, chronic respiratory failure, difficulty in walking, and diabetes mellitus (type 2 diabetes). R3 had diabetic foot ulcer(s) and treatments included application of dressings to feet. R3's care plan dated 6/7/25, identified he had	20265		

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20265	Continued from page 3 diabetes. Interventions included check all of body for breaks in skin per protocol and treat promptly as ordered by doctor. The care plan identified an actual impairment in skin integrity related to diabetes with left heel diabetic ulcer. Interventions included follow facility protocols for treatment of injury, wedge pillow to offload heel, encourage good nutrition and hydration in order to promote healthier skin, and obtain blood work and labs of any open wounds as ordered by physician. R3's wound care provider note dated 5/15/25, identified a left heel diabetic ulcer measuring 3.1 cm long by 1.8 cm wide by 0.2 cm deep with total area of 5.58 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions noted: clean with Vashe (brand of wound cleanser containing hypochlorous acid), pat dry, skin prep, apply Santyl (brand of collagenase ointment used to break down dead tissue in a wound) and calcium alginate (alginate dressing), ABD (ABD pad) and wrap, change three times weekly and as needed. R3's corresponding Skin and Wound Evaluation dated 5/15/25, identified the wound's measurements and the progress was stable. R3's progress note dated 5/16/25, indicated the IDT met and reviewed R3's skin. He had a diabetic [ulcer] to left heel "noted to be stable." He was followed weekly by the wound care provider. Treatment orders changed from Medihoney to Santyl and calcium alginate. Plan of care reviewed and up to date. R3's physician order with start date 5/17/25 and end date 5/23/25, was for diabetic left heel ulcer treatment and directed clean with wound cleanser, pat dry, Santyl, calcium alginate, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. R3's wound care provider note dated 6/12/25, identified a left heel diabetic ulcer measuring 7.3 cm long by 2 cm wide by 0.2 cm deep with total area of 14.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. Notification	20265		

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20265	Continued from page 4 section indicated R2's primary care physician, medical doctor (MD)-A, was notified, though did not specify what MD-A was notified about. R3's corresponding Skin and Wound Evaluation dated 6/12/25, identified the wound's measurements and the progress was stable. There was 100% granulation tissue, no evidence of infection, moderate serosanguineous drainage, no odor, periwound erythema with normal temperature, no pain, intact dressing, cleansing solution of Vashe, enzymatic debridement, primary dressing of calcium alginate and other (collagen particles, Santyl, ABD pad), and secondary dressing of compression wrap. R3's progress note dated 6/13/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date. R3's physician order with start date 6/17/25, was for diabetic ulcer left heel treatment with the same treatment directions as order dated 5/24/25. The order directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. During an interview on 6/18/25 at 8:25 a.m., licensed practical nurse (LPN)-C was a nurse manager. LPN-C stated nurse managers did wound rounds with the wound care provider and she was part of wound rounds for R3. R3 had a diabetic ulcer on his heel. LPN-C reviewed R3's Skin and Wound Evaluations and corresponding wound photos. LPN-C noted the 6/12/25 photo showed three open areas on R3's heel as compared to one open area in photo dated 5/15/25. R3's skin appeared to be cracking and two more areas had opened up since 5/15/25. LPN-C stated the wound "looks like it is deteriorating." She identified the wound was no longer improving and from evaluations and photos from 5/8/25 through 6/12/25 the wound had increased in size, the periwound area looked worse, and there were more open areas. LPN-C explained she was not an expert, but the wound was "not looking good" and looked "worse than it did last week." LPN-C was not aware of R3's physician, MD-A, having been notified of the deteriorating wound, but thought she may have mentioned it to the nurse practitioner but did not have documentation reflecting this notification.	20265		

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20265	Continued from page 5 LPN-C confirmed that though the Wound Evaluation dated 6/12/25 indicated MD-A had been notified (of unspecified details), she had not notified MD-A of the wound's deterioration. LPN-C stated for a deteriorating wound the primary provider and wound care providers should be notified and updated treatments orders obtained and entered. LPN-C confirmed she did not see any documentation that R3's primary providers were updated about the wound's deterioration and did not see any indication the treatment or plan of care had changed since the new orders from the wound care provider a month ago. During an observation and interview on 6/18/25 at 9:29 a.m., LPN-C removed the dressing dated 6/17/25 from R3's left foot. The ABD pad had serosanguinous drainage present that had gone through the alginate dressing underneath it. Three open areas were observed on R3's foot. LPN-C noted the largest and original open area looked "worse" and "bigger" than it had last week and it had grown in length and was almost connected to the newer smaller open area present beneath it. LPN-C stated she was going to call and notify the provider and see what they wanted to do for treatment because maybe the current treatment wasn't working. During an interview on 6/18/25 at 11:05 a.m., nurse manager registered nurse (RN)-C stated she would wait roughly a week or two weeks to determine if a treatment was working or a wound was deteriorating. If a wound was worsening in progress, the primary provider and wound care providers should be notified. During an interview on 6/18/25 at 11:05 a.m., the director of nursing (DON) stated for a wound that was deteriorating both the wound care provider and primary care provider should be updated. If a wound was deteriorating staff needed to have a conversation with the provider and try to do a root cause analysis to see why it was deteriorating. During an interview on 6/18/25 at 10:14 a.m., nurse practitioner (NP)-B stated she was covering for MD-A's usual nurse practitioner. NP-B stated she had not been notified of R3's worsening diabetic left foot ulcer wound and would review documentation for indication that MD-A or the other nurse practitioner had been notified .... In a continued interview at 12:38 p.m., NP-B stated she did not see any documentation that the facility had notified R3's primary care team of his	20265		

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20265	Continued from page 6 wound deteriorating. NP-B confirmed she would expect the primary care team to be notified of a wound increasing in size or new open areas. NP-B stated this was important because they may want to draw labs, make sure there was no osteomyelitis (bone infection), see what could be precipitating the issue of wound healing, or see what else they could do. NP-B stated notification should be made and documented. Facility policy titled Notification of Changes Policy dated 3/2024, included "It is the policy of this facility that changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician) ... The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated Non-Physician Practitioner and notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition or change in room or roommate to the parties who will make decisions about care, treatment and preferences to address the changes." SUGGESTED METHOD OF CORRECTION: The facility could review existing policies and procedures related to notification of change in resident health status. The Director of Nursing (or designee) could educate nursing staff to those policies and procedures and conduct measurable audits, to verify notification to appropriate parties occurred related to a change in health status or condition. The DON or designee should bring the results of those audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20265		
20625	Clinical Record Contents; In General CFR(s): MN Rule 4658.0450 Subp. 1 A-P Subpart 1. In general. Each resident's clinical record,	20625	Corrected	07/28/2025

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20625	Continued from page 7 including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite;	20625		

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20625	Continued from page 8 O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to maintain complete, accurate, and up-to-date medical records of administered wound care treatments for 1 of 3 residents (R1) reviewed for non-pressure related skin injuries. Findings include: R1's Minimum Data Set (MDS) assessment dated 5/19/25, indicated she admitted to the facility on 5/13/25 with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R1 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment. R1's physician order with start date 5/14/25 and end date 5/15/25, directed to continue large wound VAC and dressing on right buttock wound, change Monday Wednesday and Friday, suction at 125 millimeters of mercury (mm Hg). R1's medication administration records (MAR) progress note dated 5/14/25, indicated the wound VAC was not changed as staff were waiting for the wound VAC. R1's progress note dated 5/15/25, indicated the wound VAC arrived and was placed on the right gluteal wound, wound provider present and assessed wound at that time. R1's physician order with start date 5/19/25, directed to continue wound VAC on right buttock wound, change Monday and Thursday, suction on 125 mm Hg.	20625		

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20625	Continued from page 9 R1's progress note dated 5/23/25 at 10:50 a.m., indicated the wound VAC alarm went off at 6:30 a.m. Licensed practical nurse (LPN)-A found that the wound VAC device had failed and was unable to be reset, called the facility's medical supply company to obtain a replacement wound VAC, and was awaiting delivery. LPN-A removed the wound VAC dressing and replaced it with a wet-to-dry dressing until the new wound VAC could be applied. R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness. During an interview on 6/16/25 at 1:54 p.m., LPN-A stated R1's wound VAC failed on 5/23/25 and she changed the dressing to a wet-to-dry dressing and was not sure if there was a physician order to do so. However, had there been an order for the wet to dry dressing she would have documented the treatment as complete under the order on the treatment administration record (TAR). LPN-A stated the new wound VAC had not been delivered by the end of her shift on 6/23/25, so another nurse had changed the wet-to-dry dressing back to the wound VAC after it arrived. During an interview on 6/18/25 at 11:50 a.m., registered nurse (RN)-D stated she had worked with R1 when she went to the hospital on 5/24/25 and confirmed R1 left with her wound VAC dressing in place. RN-D stated R1's wound VAC had failed earlier and she had taken out the wet-to-dry dressing and put the new dressing and new wound VAC on that morning before R1 went to the hospital. R1's medication and treatment administration record (MAR/TAR) dated 5/1/25 through 5/31/25, included documented wound VAC dressing changes on the following dates: 5/19/25 and 5/22/25. R1's MAR/TAR lacked documentation of the following wound care treatments: - Wound VAC dressing change on 5/15/25 by wound care provider - Wet-to-dry dressing change on 5/23/25 by LPN-A	20625		

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20625	Continued from page 10 - Wound VAC dressing change on 5/24/25 by RN-D During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound VAC malfunctioned on 5/23/25 and a wet-to-dry dressing was applied. RN-C confirmed R1's record lacked an order for the wet-to-dry dressing and documentation of the wet-to-dry dressing change on 5/23/25. RN-C stated there were issues with R1's wound vac dressing when she went to the hospital on 5/24/25, but she did not know who had placed the wound VAC dressing because the removal of the wet-to-dry dressing and replacement of the wound VAC dressing was not documented. In a follow-up interview on 6/18/25 at 10:41 a.m., RN-C stated she did not see any documentation that R1's dressing was changed with wound VAC reapplied prior to her hospital transfer on 5/24/25, though remembered R1 leaving with her wound VAC. She would expect this to be documented. RN-C noted that if transferred, a receiving provider would determine when a dressing was last changed based on the MAR/TAR, which wouldn't be correct if the treatments were not documented; medical record accuracy was needed to know what cares had been provided and what needed to be done. RN-C confirmed R1's medical record was not complete or accurate. During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated wound care treatments should be documented in treatment orders (TAR). The DON noted it was important for medical records to be complete and accurate because medical records act as a guide for providing patient care. He "absolutely" expected medical records to be complete and accurate. Facility policy regarding contents of medical records requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on the maintenance of medical records and documentation of treatments administered. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could audit to ensure each resident's clinical record is complete and accurate and report these findings to their QAPI committee.	20625		

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20625	Continued from page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20625		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess non-pressure related skin wounds for 2 of 3 residents (R1, R2) reviewed for non-pressure related skin wounds. In addition, the facility failed to administer non-pressure related skin wound treatments in accordance with physician orders for 1 of 3 residents (R1) and failed to identify deterioration of a non-pressure related skin wound for 1 of 3 residents (R3) reviewed for non-pressure related skin wounds. Findings include: R1 R1's Minimum Data Set (MDS) assessment dated 5/19/25, indicated she admitted to the facility on 5/13/25 with diagnoses including non-pressure chronic ulcer of buttock, encounter for surgical aftercare following surgery on the skin and subcutaneous tissue, and cellulitis of buttock (bacterial infection of skin and underlying tissues). R3 had recent major surgery of repair of a deep ulcer and had a surgical wound with surgical wound care treatment. R3 was cognitively intact. R1's Skin Evaluation and Skin Risk Factors assessment dated 5/14/25, identified she had a surgical incision on her coccyx (tail bone) with treatment of a wound vacuum-assisted closure (VAC, a negative pressure wound therapy (NPWT) that applies suction via Granufoam, a	20830	Corrected	07/28/2025

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20830	Continued from page 12 foam dressing, applied to the wound bed connected to a portable vacuum pump with a drainage tube that removes fluid draining from the wound). R1's care plan dated 5/14/25, identified she had an alteration in skin integrity with right gluteal surgical wound with a wound VAC. Interventions included treatment to open areas per order, weekly measurement and assessment of wound, monitor for skin breakdown and signs/symptoms of infection and report to providers, document on skin condition and keep providers informed of changes. R1's physician order with start date 5/14/25 and end date 5/15/25, directed to continue large wound VAC and dressing on right buttock wound, change Monday Wednesday and Friday, suction at 125 millimeters of mercury (mm Hg). R1's medication administration record (MAR) progress note dated 5/14/25, indicated the wound VAC was not changed as staff were waiting for the wound VAC. R1's progress note dated 5/15/25, indicated the wound VAC arrived and was placed on the right gluteal wound, wound provider present and assessed wound at that time. R1's physician order with start date 5/19/25, directed to continue wound VAC on right buttock wound, change Monday and Thursday, suction on 125 mm Hg. R1's surgical clinic follow-up visit note by nurse practitioner (NP)-A dated 5/22/25, indicated R1's wound vac was removed but not able to be replaced as supplies were not sent with her. NP-A placed a wet-to-dry dressing and covered with an abdominal pad (ABD pad, an absorbent gauze dressing). Orders included change wound vac dressing on Monday, Wednesday, and Friday, "do not place sponge on top of healthy skin," cut foam to fit inside wound, and call if questions. R1's MAR dated 5/1/25 through 5/31/25, indicated wound VAC dressing changes were completed on 5/19/25 and 5/22/25. R1's progress note dated 5/23/25 at 10:50 a.m.,	20830		

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20830	Continued from page 13 indicated the wound VAC alarm went off at 6:30 a.m. Licensed practical nurse (LPN)-A found that the wound VAC device had failed and was unable to be reset, called the facility's medical supply company to obtain a replacement wound VAC, and was awaiting delivery. LPN-A removed the wound VAC dressing and replaced it with a wet-to-dry dressing until the new wound VAC could be applied, updated the resident, and updated the nurse manager. The progress note did not indicate the provider was contacted to notify of the wound VAC failure or obtain a new order for a wet-to-dry dressing. R1's progress note dated 5/24/25, indicated she was transferred to the hospital due to low oxygen saturations and increased weakness. R1's hospital consult note from wound, ostomy, and continence (WOC) nursing services dated 5/27/25, indicated WOC was consulted for right buttock wound. The note identified a surgical wound to right buttock with negative pressure wound therapy (wound VAC). The note also identified a suction injury wound to right buttock towards hip with contributing factor of "Granufoam to good tissue without drape [a transparent adhesive film-like acrylic and silicone dressing] placed." The note identified R1 admitted to the hospital on 5/24/25 with the wound VAC remining in place since her admission. It was removed "revealing significant suction burn from Granufoam bridge being in direct contact with good tissue." R1 experienced "significant pain" with the dressing change and the plan was to take a break from the wound VAC to allow the periwound area (skin surrounding a wound, where the suction burn was located) to heal. R1's hospital consult note from WOC nursing services dated 5/30/25, indicated the periwound area had mild improvement and the wound VAC could be resumed upon R1's discharge from the hospital. The nurse "discussed importance of protecting periwound from black sponge" and "placed discharge order." The suction injury wound was not measured, had a red wound base, moderate sanguineous (bloody) drainage, with periwound skin erythema (redness), maceration (breakdown and softening of skin due to exposure to excessive moisture), and fragile/thin. R1's hospital discharge summary dated 5/30/25, included discharge procedure orders for wound care. The orders	20830		

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20830	Continued from page 14 noted a wound VAC was in place on the right gluteal area. A wound care order for the right buttock included "Daily dressing changes with Vashe (a wound cleanser) packing done inpatient due to periwound damage from black foam being placed directly to skin prior to admission. OK to resume NPWT at discharge. Please protect periwound skin with transparent drape under any foam when bridging [using extra pieces of foam to create a connection point to the VAC device other than to the foam applied directly to the wound, often to adjust positioning of the drainage tube] SensaTRAC pad [pad on the end of the drainage tube that connects from the VAC device to the foam dressing to provide drainage and suction]." This was followed by wound VAC dressing change orders to change Mondays, Wednesdays, and Fridays with step-by-step instructions including: Apply alginate AG [alginate dressing, an absorbent wicking antimicrobial pad] to periwound wound bed; add strip of transparent drape where bridging will be applied to hold alginate AG in place; and label dressing with date, time, initial, and number of foam pieces placed in wound. R1's progress note dated 5/30/25, indicated R1 returned to the facility from the hospital. R1's physician orders with start date 5/30/25, in the electronic health record (EHR) included: monitor the wound VAC's collection canister every shift and change as needed; treatment to right buttock surgical wound of continue wound VAC, change Monday and Thursday, suction on 125 mm HG; monitor wound VAC for signs and symptoms of infection around wound VAC site and update provider as needed; and monitor function of wound VAC every shift and update provider as needed. R1's orders did not include the hospital discharge wound care orders, including step-by-step instructions for dressing changes on Mondays/Wednesdays/Fridays and application of alginate dressing. R1's MAR dated 5/30/25 through 6/16/25, indicated the treatment order for right buttock surgical wound to continue wound VAC, change Monday and Thursday, suction on 125 mm HG was completed on 6/2/25, 6/5/25, 6/9/25, 6/12/25, and 6/16/25. R1's MAR lacked evidence that wound treatment was completed in accordance with the hospital discharge wound care orders dated 5/30/25.	20830		

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20830	Continued from page 15 R1's Admission/Initial Data Collection assessment dated 5/30/25, included a skin section with area to identify alterations in skin integrity and the associated site, type, length, width, depth, and stage (if alteration was pressure-related). No alterations in skin integrity were identified. Comments included "healing skin alteration on right hip" and wound on right buttock with dressing dry and intact. The assessment lacked any further information about the new suction injury wound and did not include a comprehensive assessment of the injury. R1's Skin Evaluation and Skin Risk Factors assessment dated 5/31/25, included a current skin issues section including description of wound bed for each site, description of drainage amount and odor, description of periwound area, and current treatment. This section was blank. Question "are there any new wound[s] prompting assessment?" was marked "no." The risk factors and interventions sections were blank. The summary noted she readmitted with "new skin to periwound of buttock wound," wound VAC placed, skin prep to periwound, and wound provider to see resident next week. The assessment lacked any further information about the new suction injury wound and did not include a comprehensive assessment of the injury. R1's Weekly Skin Inspection assessment dated 6/5/25, included a summary of current skin condition with note that wound VAC was on. R1's Wound Care note dated 6/5/25, indicated R1 was seen by the wound care provider regarding surgical wound to right gluteal area. The note indicated the wound was improving with "no new area of concern." One wound was identified, a surgical right gluteal wound 7.7 cm long x 4.4 cm wide x 5.3 cm deep with moderate serosanguineous (mix of bloody and clear) exudate (drainage), identification of tissue type, periwound area positive for erythema, and note "moderate erythema." Treatment plan was continue wound VAC as ordered. The note did not identify the presence of a second wound, the suction burn injury, or include a comprehensive assessment of the wound. R1's Wound Evaluation dated 6/5/25, identified a surgical wound to right gluteus with healing ridge, other closure method, and stable progress with measurements identified in the Wound Care note from the	20830		

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20830	Continued from page 16 same day. The wound bed, periwound, and treatments sections were blank. It did not identify or include a comprehensive assessment of the suction burn injury wound. R1's Weekly Skin Inspection dated 6/12/25, included a summary of current skin condition with note "no new skin issues noted." R1's Wound Care note dated 6/12/25, indicated R1 was seen by the wound care provider regarding surgical wound to right gluteal area. The note indicated the wound was improving with "no new area of concern." One wound was identified, a surgical right gluteal wound 4.9 cm long x 3 cm wide x 4.5 cm deep with moderate serosanguineous (mix of bloody and clear) exudate (drainage), identification of tissue type, periwound area positive for erythema, and note "mild erythema." Treatment plan was continue wound VAC as ordered. The note did not identify the presence of a second wound, the suction burn injury, or include a comprehensive assessment of the wound. R1's Wound Evaluation dated 6/12/25, identified a surgical wound to right gluteus with healing ridge, other closure method, and improving progress with the measurements identified in the Wound Care note from the same day. Wound bed section identified tissue types and no evidence of infection. Periwound surrounding tissue was erythema with normal temperature. Pain level was zero. Treatment was intact dressing with generic wound cleanser and primary dressing of NPWT. It did not identify or include a comprehensive assessment of the suction burn injury wound. R1's record did not include a comprehensive assessment of the suction burn injury wound on her right gluteus/hip after she re-admitted to the facility on 5/30/25. During an interview on 6/16/25 at 12:38 pm., R1 stated she was at the facility for a wound on her right hip which was connected to a pump (wound VAC) and couldn't go home until it healed up enough that she no longer needed it. R1 stated her dressing was changed every three days. Only a couple of nurses including LPN-A did these dressing changes, and once in a while the dressing would not be right resulting in a leak causing the wound VAC to alarm. R1 noted the wound provider saw	20830		

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20830	Continued from page 17 her weekly and said the wound was getting better. R1 noted she had to go back to the hospital for a few days after she admitted to the facility, but didn't remember why. During an interview on 6/16/25 at 1:54 p.m., licensed practical nurse (LPN)-A stated she was the charge nurse for R1's unit. LPN-A noted residents had head-to-toe skin assessments completed by a nurse on admission. The next day a nurse manager or charge nurse would do another skin assessment and wound assessments. Wound assessments were then done by the wound care provider during weekly rounds. LPN-A looked in orders to know what to do for a wound including dressings and treatments. If a wound VAC failed there should be an order for an as needed wet-to-dry dressing to use instead. LPN-A noted R1's wound VAC failed on 5/23/25 and she changed the dressing to a wet-to-dry dressing. LPN-A stated she had notified the provider and been instructed to place a wet-to-dry dressing while waiting for a new wound VAC. LPN-A was not sure if R1 had the order for this or if she charted this, but she would have charted the dressing change as an as needed order and charted provider notification in a progress note. LPN-A stated she changed R1's wound VAC a couple of times, always placed a drape down beneath the bridge foam to protect intact skin, and had never seen the bridge foam in direct contact with R1's skin, though knew it had happened because R1 now had a new area of red skin. During an interview on 6/18/25 at 11:50 a.m., registered nurse (RN)-D stated she had changed R1's wound VAC dressing on the morning on 5/24/25 before R1 went to the hospital. RN-D stated R1's wound VAC had failed earlier and she had to take out the wet-to-dry dressing and put the new dressing and wound VAC on that morning. RN-D stated she placed the barrier film (drape) on top of the bridge foam and "didn't put a barrier on the bottom," and the hospital said it "ate" R1's skin. RN-D stated R1 had left for the hospital with the dressing she had applied and new wound VAC in place. RN-D stated she had not been familiar with using a foam bridge with wound VAC dressings and "wasn't sure" at the time if there was supposed to be a barrier underneath it. She proceeded the way she was trained to do for wound VACs without a bridge piece and had not sought clarification. During an observation and interview on 6/16/25 at 2:37 p.m., R1 was observed in her bed. LPN-A identified R1's	20830		

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20830	Continued from page 18 wound on her right buttock/hip with dressing she had changed earlier that day. R1's surgical wound had foam inside of it and a piece of bridge foam extending from the foam in the wound off to the right side which was connected to the drainage tubing and wound VAC, all covered with transparent drape dressings. Due to the overlapping nature of the transparent film drape dressing pieces underneath and over the foam, the drape under the bridge foam could not be specifically visualized, though LPN-A stated she had applied it. On the upper right side of the surgical wound was an area of redness extending diagonally approximately three inches identified by LPN-A as the area where the bridge foam had been previously placed without a drape underneath. LPN-A confirmed the dressing did not include initials, date, time, or number of pieces of foam used in accordance with the hospital wound care orders. In a follow-up interview at 3:44 p.m., LPN-A confirmed she did not apply an alginate dressing underneath the bridge foam when she had changed the dressing earlier that day. During an interview on 6/16/25 at 2:48 p.m., nurse manager RN-C stated R1's wound should be monitored every shift with a monitoring order nurses sign off on. RN-C confirmed wound monitoring orders were in place starting 5/30/25, but there was no order for or documentation of wound monitoring every shift from 5/13/25 to 5/24/25 prior to R1's hospitalization. RN-C noted R1's wound VAC malfunctioned on 5/23/25 and a wet-to-dry dressing applied. She expected the provider to be notified of the failure, new order obtained, and documented in a progress note. RN-C confirmed R1's record lacked an order for the wet-to-dry dressing and documentation of provider notification. RN-C stated there were issues with R1's wound vac dressing when she went to the hospital 5/24/25. The bridge was applied improperly resulting in periwound skin damage. RN-C identified R1's wound care orders came from her hospital discharge paperwork and the current order dated 5/30/25 was to change the wound VAC dressing Mondays and Thursdays with suction at 125 mm Hg. RN-C was unaware of the detailed wound care orders from R1's hospital discharge on 5/30/25. She noted the orders had been faxed to the facility prior to R1's arrival, uploaded in her EHR, but RN-C had never seen them before. RN-C stated R1's wound VAC dressing changes were done on Mondays and Thursdays in accordance with direction from the facility's wound care provider but did not see any orders in his notes directing staff to change the treatment from what the hospital ordered. RN-C confirmed R1's wound care had not been in accordance with the physician orders, and she would	20830		

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20830	Continued from page 19 expect the detailed wound care orders to be followed. During a follow-up interview on 6/17/25 at 10:58 a.m., RN-C stated the suction burn wound was considered part of the peri-wound area of the surgical wound per the wound care provider and confirmed separate wound assessments had not been completed for R1's suction burn wound. RN-C confirmed the surgical wound assessments only identified peri-wound erythema and did not include identification of the suction burn wound's etiology, treatment, measurements, or other details. She did not see assessment of the wound in the wound care provider's weekly notes or photographs that captured the entirety of the wound. RN-C was unable to identify completion of a comprehensive assessment of the suction burn wound. During an interview on 6/16/25 at 1:16 p.m., RN-B stated when residents were admitted nurses did skin assessments immediately and checked for any wounds. Wounds were assessed when doing dressing changes and with weekly skin assessments. Wound care orders were on the MAR and treatments were documented on the MAR. RN-B stated wound VAC dressings had to have a film dressing underneath bridging foam if it was used to avoid skin irritation around the wound. If a wound VAC needed to be changed but supplies were not available, she would call the provider, let them know, and get an order for a different dressing. During an interview on 6/16/25 at 1:00 p.m., RN-A stated nurses did wound care based on physician orders in the MAR, including procedures and dressings. Everything was put in the MAR unless there was a new admit and then "you use the discharge orders." Treatments were charted in the MAR. Wound assessments were completed by nurse managers on admission, by nurses when doing dressing changes, and by the wound care provider who came once weekly. RN-A stated for wound VAC dressing changes, you had to put down a protective barrier over the skin before placing the bridging foam to protect the good skin because it could create a new wound from all the moisture passing through the foam. RN-A noted nurse managers performed wound VAC dressing changes. If a dressing change was needed but supplies were unavailable, RN-A would notify the provider and get an order for a different dressing while waiting for supplies. During an interview on 6/18/25 at 11:05 a.m., the interim director of nursing (DON) stated all wounds were to be comprehensively assessed on admission and at	20830		

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20830	Continued from page 20 least weekly thereafter. A comprehensive assessment included how the wound looks, drainage, wound bed description and size, the treatments, description of the wound bed and periwound area, presence of tunneling or maceration, wound status of improving deteriorating or stable, and pain. He expected all components of the facility's wound assessments to be completed as part of a comprehensive assessment. On admission, treatment orders from the hospital should be followed for any alterations in skin integrity. The DON confirmed treatments should be in accordance with provider orders. Treatments should be documented and if anything was not done per orders or if orders were missing, nurses should notify the provider. He would expect the provider to be called if a wound VAC failed to notify them of the failure and get an order for a new treatment. The DON confirmed R1's wound vac had not been applied properly with a barrier between the bridge foam and intact skin leading to skin breakdown. During an interview on 6/18/25 at 9:41 a.m., NP-A stated she was part of the surgical clinic team and had seen R1 for a surgical follow-up appointment on 5/22/25 with plan to see her again in a month, but she was re-admitted to the hospital where documentation showed a suction burn injury from the wound VAC. NP-A confirmed R1 was discharged with "specific orders for how to change the wound vac" from the surgical team. NP-A would expect orders that are part of discharge instructions to be transcribed and followed. NP-A stated, "our intention was for these to be followed until she came back in" and noted she did not see evidence that the surgical team had been contacted regarding wound VAC failure, treatment orders, or consultation regarding management of the wound VAC. NP-A noted not following the orders could lead to maceration with the periwound area eroding or denuding which could "delay healing" or "make the wound potentially worse." R2 R2's MDS assessment dated 6/8/25, indicated she admitted to the facility on 5/22/25 with entry on 6/2/25 from the hospital. R2 had diagnoses including other fracture and mechanical complication of internal right hip prosthesis (problem with an artificial hip joint). R2 had orthopedic surgery to repair a fracture of the pelvis, hip, leg, knee, or ankle during the prior inpatient hospital stay requiring active care at the facility and a surgical wound.	20830		

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20830	Continued from page 21 R2's progress note dated 6/2/25, indicated she re-admitted to the facility following a hospital stay for abdominal distention secondary to an ileus. R2's care plan dated 5/23/25, identified she had an alteration in skin integrity related to surgical intervention with surgical wound to hip. Interventions included: monitor skin integrity daily during cares and weekly skin inspection by nurse, treatment to open areas per order, weekly measurements and assessment of wound, and document on skin condition and keep provider informed of changes. R2's physician orders dated 6/2/24, included: monitor surgical incision site for signs and symptoms of infection and healing every shift; and do not apply creams, lotions, powder, or hydrogen peroxide to the incision. R2's Skin Evaluation and Skin Risk Factors assessment dated 6/2/25, identified a surgical incision to right hip with Steri-Strips (brand of thin adhesive bandages used to close incisions) in place. It did not include additional information about the wound or include measurements. R2's Orthopedic Progress Note and Provider Orders document dated 6/4/25, indicated R2 was seen that day for three to five week post-operative visit following a right femur fracture with revision femoral implant (fracture of the thigh bone near a hip replacement implant requiring revision surgery to replace the original implant). Orders included "Wound care: incision looks good, sutures were removed. Steri Strips to fall off on their own. Ok for incision to get wet in the shower." R2's Wound Evaluation dated 6/4/25, identified a front right hip surgical incision with Steri-Strips present on admission. There was no evidence of infection in the wound bed, no exudate or odor, the periwound edges were attached with surrounding tissue normal in color, no induration or edema, normal temperature, and intermittent three out of ten pain. There was no dressing present and the wound was improving. The dimensions section for measurements of the wound was blank.	20830		

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20830	Continued from page 22 R2's Weekly Skin Inspection dated 6/4/25, noted a shower was completed and R2 had an incision to right hip. It did not include additional information about the wound or include measurements. R2's Wound Evaluation dated 6/12/25, identified a front right hip surgical incision with Steri-Strips present on admission. It measured 3.73 centimeters (cm) long by 0.47 cm wide. The wound bed, periwound, and treatment sections were blank. The wound's progress was improving with note that "the resident has Steri strips in place healing well staff will continue to monitor wound for changes." On 6/17/25 at 9:48 a.m., R2's right hip surgical incision was observed while she was lying in bed. The incision extended down R2's outer thigh from her hip and had Steri-Strips in place near the middle portion of the incision line. Nurse manager, RN-C, stated the incision appeared approximately 16 inches long, there were four Steri-Strips present across the incision line which appeared to be closed, and the periwound area had dry skin and looked healthy. During an interview on 6/17/25 at 10:00 a.m., nurse manager RN-C stated she completed R2's Wound Evaluation dated 6/4/25. RN-C confirmed the assessment lacked measurements and she would expect a wound assessment to include measurements. RN-C reviewed R2's Wound Evaluation and attached wound photo dated 6/12/25 and stated the measurements were not accurate because the program that calculated measurements from the photo had only picked up on the small scabbed area remaining in the middle of the incision. RN-C stated the assessment did not identify anything in the wound bed section but should have noted the scab and did not identify anything in the periwound section but she would have put dry flaky skin, edges attached or epithelization with new pink sin. Further, it did not identify if there was evidence of infection, exudate, odor, induration, edema, temperature, or pain. RN-C stated a comprehensive assessment of the wound had not been completed, it should have been done, and the 6/4/25 Wound Evaluation should have included measurements to be comprehensive. R3	20830		

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20830	Continued from page 23 R3's MDS assessment dated 5/23/25, indicated he admitted to the facility with 6/7/24 and had diagnoses including non-pressure chronic ulcer of left heel and midfoot, morbid obesity, chronic respiratory failure, difficulty in walking, and diabetes mellitus (type 2 diabetes). R3 had diabetic foot ulcer(s) and treatments included application of dressings to feet. R3's care plan dated 6/7/25, identified he had diabetes. Interventions included check all of body for breaks in skin per protocol and treat promptly as ordered by doctor. The care plan identified an actual impairment in skin integrity related to diabetes with left heel diabetic ulcer. Interventions included follow facility protocols for treatment of injury, wedge pillow to offload heel, encourage good nutrition and hydration in order to promote healthier skin, and obtain blood work and labs of any open wounds as ordered by physician. R3's wound care provider note dated 5/15/25, identified a left heel diabetic ulcer measuring 3.1 cm long by 1.8 cm wide by 0.2 cm deep with total area of 5.58 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions noted: clean with Vashe (brand of wound cleanser containing hypochlorous acid), pat dry, skin prep, apply Santyl (brand of collagenase ointment used to break down dead tissue in a wound) and calcium alginate (alginate dressing), ABD (ABD pad) and wrap, change three times weekly and as needed. R3's corresponding Skin and Wound Evaluation dated 5/15/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, wound pain, and treatments sections were blank. R3's progress note dated 5/16/25, indicated the IDT met and reviewed R3's skin. He had a diabetic [ulcer] to left heel "noted to be stable." He was followed weekly by the wound care provider. Treatment orders changed from Medihoney to Santyl and calcium alginate. Plan of care reviewed and up to date. R3's physician order with start date 5/17/25 and end date 5/23/25, was for diabetic left heel ulcer treatment and directed clean with wound cleanser, pat	20830		

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20830	Continued from page 24 dry, Santyl, calcium alginate, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. R3's wound care provider note dated 5/22/25, identified a left heel diabetic ulcer measuring 2.6 cm long by 1.6 cm wide by 0.2 cm deep with total area of 4.16 cm squared with progress of improving. Exudate was moderate serosanguineous with 90% granulation and 10% slough tissue and presence of periwound maceration with note mild maceration. Treatment plan was updated and instructions noted: clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate and Santyl, ABD and wrap, change three times weekly and as needed. R3's corresponding Skin and Wound Evaluation dated 5/22/25, identified the wound's measurements and progress was improving. The wound bed, exudate, periwound, wound pain, and treatments sections were blank. R3's progress note dated 5/23/25, indicated the IDT met to review R3's wound. Diabetic ulcer was improving. Wound care provider continued to follow. Current treatment would continue with no new areas of concern. Plan of care was up to date. R3's physician order with start date 5/24/25 and end date 6/16/25, was for diabetic ulcer left heel treatment and directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. R3's wound care provider note dated 5/29/25, identified a left heel diabetic ulcer measuring 3.5 cm long by 1.6 cm wide by 0.2 cm deep with total area of 5.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and no periwound erythema. Treatment instructions were unchanged. R3's corresponding Skin and Wound Evaluation dated 5/29/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, wound pain, and treatment sections were blank.	20830		

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20830	Continued from page 25 R3's progress noted ate 5/30/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound care provider continued to follow and current treatment to continue. Plan of care was up to date. R3's wound care provider note dated 6/5/25, identified a left heel diabetic ulcer measuring 6.4 cm long by 1.5 cm wide by 0.2 cm deep with total area of 9.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. R3's corresponding Skin and Wound Evaluation dated 6/5/25, identified the wound's measurements and progress was stable. The wound bed, exudate, periwound, pain, and treatment sections were blank. R3's progress note dated 6/6/25, indicated the IDT met to review R3's wound. Diabetic ulcer was stable with no signs or symptoms of infection. Wound care provider continued to follow with current treatment to continue. Plan of care was up to date. R3's wound care provider note dated 6/12/25, identified a left heel diabetic ulcer measuring 7.3 cm long by 2 cm wide by 0.2 cm deep with total area of 14.6 cm squared with progress of stable. Exudate was moderate serosanguineous with 100% granulation tissue and presence of periwound erythema with note mild erythema. Treatment instructions were unchanged. R3's corresponding Skin and Wound Evaluation dated 6/12/25, identified the wound's measurements and progress was stable. There was 100% granulation tissue, no evidence of infection, moderate serosanguineous drainage, no odor, periwound erythema with normal temperature, no pain, intact dressing, cleansing solution of Vashe, enzymatic debridement, primary dressing of calcium alginate and other (collagen particles, Santyl, ABD pad), and secondary dressing of compression wrap. R3's progress note dated 6/13/25, indicated the IDT met to review R3's wound. Diabetic ulcer was noted to be stable with no signs or symptoms of infection. Wound	20830		

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20830	Continued from page 26 care provider continued to follow with current treatment to continue. Plan of care was up to date. R3's physician order with start date 6/17/25, was for diabetic ulcer left heel treatment with the same treatment directions as order dated 5/24/25. The order directed clean with Vashe, pat dry, skin prep, apply collagen particles, calcium alginate, and Santyl, ABD and wrap, change three times weekly and as needed every Tuesday, Thursday, and Saturday. Review of R3's medication and treatment administration records (MAR/TAR) dated months of May and June 2025, identified documentation of treatments completed in accordance with physician orders as scheduled. The ordered treatments were completed on 5/17/25, 5/22/25, 5/24/25, 5/27/25, 5/31/25, 6/3/25, 6/5/25, 6/10/25, 6/12/25, 6/14/25, and 6/17/25. Dressing change on 5/29/25 was documented as not completed, but corresponding MAR progress note dated 5/29/25 indicated it had already been done that day. During an interview on 6/17/25 at 12:25 p.m., LPN-B stated R3 had a diabetic ulcer on his left heel. Treatment was to clean with Vashe and then pat dry, prep the skin, cover with calcium alginate, collagen, Santyl, then apply an ABD pad and wrap it. This dressing was changed three days per week. LPN-B thought the ulcer was getting better because it wasn't draining a lot and was kind of closing up. During an interview on 6/17/25 at 12:35 p.m., R3 stated he had a wound on his left foot that staff would wrap and put some stuff on three days a week. The wound team looked at it on Thursdays. R3 noted LPN-B had changed his dressing earlier that morning. During an interview on 6/18/25 at 8:25 a.m., nurse manager LPN-C stated nurse managers did wound rounds with the wound care provider and she was part of wound rounds for R3. LPN-C stated R3 had a diabetic ulcer on his heel. LPN-C reviewed R3's Skin and Wound Evaluations and corresponding wound photos and noted the measurements were not always correct because of the program used to measure the wounds automatically based on the photos. LPN-C stated she had to manually draw part of the area for measurement on the 6/12/25 assessment and it went past the edge of the wound. LPN-C noted that the 6/12/25 photo showed three open	20830		

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20830	Continued from page 27 areas on R3's heel as compared to one open area in photo dated 5/15/25. LPN-C stated R3's skin appeared to be cracking and two more areas had opened up since 5/15/25. LPN-C stated the wound "looks like it is deteriorating." LPN-C stated the wound care provider would determine how the wound looked and that's what she would document. She identified the wound was no longer improving and from evaluations and photos from 5/8/25 through 6/12/25 the wound had increased in size, the periwound area looked worse, and there were more open areas. LPN-C did not endorse having previously identified that the wound was worsening, though stated she had manually circled the third open area in the photo dated 6/12/25 because she noticed it was a new spot and let the wound care provider know. LPN-C stated she was sure she mentioned to R3's primary nurse practitioner that his wound care orders had changed, but could not articulate when and how it was identified and addressed that R3's wound was deteriorating. LPN-C noted staff had to wait a few weeks to see if a new treatment was working and give the wound time to heal, and noted it had been a month since R3's orders had changed. LPN-C was unsure of the protocol for the length of time a wound for following a wound before determining that it was not improving and adjusting treatments. LPN-C stated she was not an expert, but the wound was "not looking good" and looked "worse than it did last week." She noted the weekly IDT wound meetings included the nurse managers and R3's wound was documented in IDT progress notes as stable because that is what was in the wound care provider notes. LPN-C noted she did not see any documentation identifying the wound as deteriorating or indication that the treatment or plan of care had changed since the wound care orders were updated a month prior. On 6/18/25 at 9:29 a.m., LPN-C removed the dressing dated 6/17/25 from R3's left foot. The ABD pad had serosanguinous drainage present that had gone through the alginate dressing underneath it. Three open areas were observed on R3's foot. LPN-C noted the largest and original open area looked "worse" and "bigger" than it had last week and it had grown in length and was almost connected to the newer smaller open area present beneath it. LPN-C stated she was going to call and notify the provider and see what they wanted to do for treatment because maybe the current treatment wasn't working. During an interview on 6/18/25 at 10:41 a.m., nurse manager RN-C stated if a wound was deteriorating the dressing (treatment) needed to be changed right away,	20830		

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20830	Continued from page 28 staff needed to do something different. She would wait roughly a week, maybe two weeks, depending on how often dressing changes were done before determining if a treatment was effective or not. During an interview on 6/18/25 at 11:05 a.m., the DON stated both the wound care provider and primary care provider should be updated if a wound was deteriorating and staff should be constantly updating the provider. The DON stated he was not sure what the specific protocol was at the facility for the time frame was for making a determination about a wound's progress, but standard care was to wait two weeks and if the wound was still deteriorating have a conversation with the provider and try to do a root cause analysis to see why it was deteriorating. Further, the root cause analysis should be done every week at the IDT wound meetings, though he had just started and not yet been present at this meeting. The DON noted signs of wound deterioration included increased exudate, slough in the wound, an increase in eschar, if the area was bigger than it was previously, increase in pain, or new open areas. The DON reviewed R3's wound photos and stated if he saw that he would question the provider and advocate for the resident if it was identified as stable or improving as in the wound's documentation. He would expect a wound increasing in size to be identified in the IDT wound review. Facility policy titled Skin Assessment & Wound Management dated 2/25, included a section for non-pressure wounds and altered skin integrity. The section for a new skin problem included "When a significant alteration in skin integrity is noted; (i.e., large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken: 7. Notify Provider/Treatment Ordered. 8. Notify resident representative. 9. Complete education with resident/resident representative including risks & benefits. 10. Initiate Skin and Wound Evaluation. 11. Notify Nurse Manager/Wound Nurse. 12. Referral to dietary, if appropriate. 13. Referral to therapies, if appropriate. 14.Review and update care plan including interventions. 15.Update resident care lists. 16.Update Care Plan to identify risks for skin breakdown." The section for ongoing skin issues included, "Follow ongoing treatments per provider order. Update provider and resident/representative as needed. Update care plan as needed."	20830		

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20830	Continued from page 29 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review/revise policies and procedures on management of non-pressure related skin wounds including assessment, monitoring, and treatment and review all residents with non-pressure related skin wounds to assure they are receiving ongoing assessment and monitoring of the wounds along with necessary treatment/services in accordance with physician orders. The administrator, DON, or designee could educate all staff on these policies and procedures. The administrator, DON, or designee could conduct random audits of the delivery of care and review nursing assessments to ensure appropriate care and services are implemented. The administrator, DON, or designee could then take that information to their quality assessment and performance improvement (QAPI) committee to assess the need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		