Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 31, 2023

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: CCN: 245201
Cycle Start Date: December 13, 2022

Dear Administrator:

On January 24, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2023

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Re: Reinspection Results
Event ID: KJNH12

Dear Administrator:

On January 24, 2023 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 December 13, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

RE: CCN: 245201
Cycle Start Date: December 13, 2022

Dear Administrator:

On December 13, 2022, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 13, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 13, 2023 (six months after the

identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245201	A. BUILDING _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/13/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52016540C (MN00089117), with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		1/10/23

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

Electronically Signed | 01/04/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor and assess residents risk for pressure ulcers to prevent the development of pressure ulcers for 3 of 3 residents (R1, R2, R3) reviewed for pressure ulcers. Findings include: R1's annual Minimum Data Set (MDS) assessment dated 8/17/22, indicated R1 had mild cognitive impairment and required total assistance for bed and transfer mobility. Furthermore, R1's MDS indicated R1 had diagnoses of Parkinson's disease, diabetes, and chronic pressure ulcer. R1's provider order dated 8/15/22, directed staff to complete weekly skin assessment and document on the weekly skin inspection forms. Furthermore, the order read if the resident refused, to indicate on the weekly skin inspection form. R1's care plan dated 8/17/22, indicated R1 was at risk for skin breakdown related to limited movement and history of pressure injuries. R1's care plan directed nurses to complete a weekly skin inspection on bath days. A review of R1's medical record lacked indication R1 had or refused a weekly skin assessment from 9/26/22- 10/4/22.	F 686	R1 has discharged from facility, R2 and R3 still resides at facility. All residents have the potential to be affected. Full house audit completed to ensure all residents have had a skin check in the past week. Nursing staff will be educated on completion of resident weekly skin assessments. Skin checks will be reviewed weekly by IDT to ensure completion ongoing. DON or designee will audit all current residents weekly to ensure resident skin audits are completed during the facility Interdisciplinary meeting for one month, then five residents weekly for one month to ensure weekly skin checks are completed. The facility will review skin audit compliance and F686 regulation for the next 2 QAPI meetings.	

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F 686	Continued From page 2 R2's admission MDS dated 11/28/22, indicated R2 has severe cognitive impairment and required extensive assist with one person for bed mobility and total assist with two person for transfers. R2's MDS further indicated R2 had diagnoses of weakness and cerebral vascular accident (stroke). R2's provider order dated 11/21/22, directed staff to complete weekly skin assessment and document on the weekly skin inspection forms. R2's care plan dated 11/22/22, indicated R2 was at risk for alteration in skin integrity related to a history of ankle wound. Furthermore, R2's care plan directed nurses to complete a weekly skin inspection. A review of R2's medical record lacked indication R2 had or refused a weekly skin assessment from 11/28/22- 12/14/22. R3's annual MDS dated 9/13/22, indicated R3 was cognitively intact and required total assistance with 2 persons for bed mobility and transfers. Furthermore, R3's MDS indicated R3 had diagnoses of chronic obstructive pulmonary disease and weakness. R3's provider order dated 4/12/21, directed staff to complete weekly skin assessment and document on the weekly skin inspection forms. Furthermore, the order stated if the resident refused, to indicate on the weekly skin inspection form. R3's care plan dated 8/16/22, indicated R3 was at risk for breakdown related to morbid obesity,	F 686		

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F 686	Continued From page 3 history of shear injury and refusal of skin checks. Furthermore, R3's care plan directed nurses to complete a weekly skin inspection. A review of R3's medical record lacked indication R3 had or refused a weekly skin assessment from 11/14/22- 12/14/22. When interviewed on 12/13/22, at 12:20 p.m. nursing assistant (NA)-A stated when residents have a bath or shower, the nurse was notified right before the resident was dressed to complete a skin assessment. If a resident refused the bath nurses had to be notified so a skin check was still completed. When interviewed on 12/13/22, at 12:40 p.m. registered nurse (RN)-A stated weekly skin assessments were required for residents when showers or baths were completed. Nursing assistants notified nurses when the bath was completed, and the resident was ready for the skin assessment. RN-A stated if residents refused a bath, the nurse had to still complete a skin assessment during that time. If the resident refused a skin assessment the nurse should re-approach a few times. RN-A further stated the weekly skin assessment had to be documented even if the resident refused. RN-A verified R1, R2, and R3 were at risk for pressure injuries and R1, R2, and R3's medical records lacked weekly skin assessments. RN-A further stated R1 and R3 were able to make their needs known and were known to refuse cares at times, but the refusal should have been documented. R2 was on hospice care and the hospice aid helps with bathing. RN-A stated even with hospice support, the weekly skin assessment was still required.	F 686		

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F 686	Continued From page 4 When interviewed on 12/13/22, at 2:56 p.m. the Director of Nursing (DON) stated a skin assessment was completed upon admission and then weekly assessments were completed on the resident's bath day. DON expected the weekly skin assessments to be completed even if the resident refused a bath. Furthermore, staff were expected to document any resident refusal of skin assessments. DON verified R1, R2, and R3's missing weekly skin assessments. DON stated completing weekly skin assessments for residents was important to identify new skin concerns. Early identification was important so interventions or treatment could be started. A facility policy titled Skin Assessment and Wound Management dated 7/2018, directed residents will have a weekly skin assessment by a licensed staff.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

Administrator
The Estates At Fridley LLC
5700 East River Road
Fridley, MN 55432

Re: State Nursing Home Licensing Orders
Event ID: KJNH11

Dear Administrator:

The above facility was surveyed on December 13, 2022 through December 13, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	C 12/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/13/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H52016540C (MN00089117), with a licensing orders issued at 0900. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to monitor and assess residents risk for pressure ulcers to prevent the development of pressure ulcers for 3 of 3 residents (R1, R2, R3) reviewed for pressure ulcers. Findings include:	2 900	corrected	1/10/23

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THE ESTATES AT FRIDLEY LLC	5700 EAST RIVER ROAD FRIDLEY, MN 55432

(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) COMPLETE DATE
2 900	Continued From page 3 R1's annual Minimum Data Set (MDS) assessment dated 8/17/22, indicated R1 had mild cognitive impairment and required total assistance for bed and transfer mobility. Furthermore, R1's MDS indicated R1 had diagnoses of Parkinson's disease, diabetes, and chronic pressure ulcer. R1's provider order dated 8/15/22, directed staff to complete weekly skin assessment and document on the weekly skin inspection forms. Furthermore, the order read if the resident refused, to indicate on the weekly skin inspection form. R1's care plan dated 8/17/22, indicated R1 was at risk for skin breakdown related to limited movement and history of pressure injuries. R1's care plan directed nurses to complete a weekly skin inspection on bath days. A review of R1's medical record lacked indication R1 had or refused a weekly skin assessment from 9/26/22- 10/4/22. R2's admission MDS dated 11/28/22, indicated R2 has severe cognitive impairment and required extensive assist with one person for bed mobility and total assist with two person for transfers. R2's MDS further indicated R2 had diagnoses of weakness and cerebral vascular accident (stroke). R2's provider order dated 11/21/22, directed staff to complete weekly skin assessment and document on the weekly skin inspection forms. R2's care plan dated 11/22/22, indicated R2 was at risk for alteration in skin integrity related to a	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00935	A. BUILDING: _____ B. WING _____	C 12/13/2022

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2 900	Continued From page 4 history of ankle wound. Furthermore, R2's care plan directed nurses to complete a weekly skin inspection. A review of R2's medical record lacked indication R2 had or refused a weekly skin assessment from 11/28/22- 12/14/22. R3's annual MDS dated 9/13/22, indicated R3 was cognitively intact and required total assistance with 2 persons for bed mobility and transfers. Furthermore, R3's MDS indicated R3 had diagnoses of chronic obstructive pulmonary disease and weakness. R3's provider order dated 4/12/21, directed staff to complete weekly skin assessment and document on the weekly skin inspection forms. Furthermore, the order stated if the resident refused, to indicate on the weekly skin inspection form. R3's care plan dated 8/16/22, indicated R3 was at risk for breakdown related to morbid obesity, history of shear injury and refusal of skin checks. Furthermore, R3's care plan directed nurses to complete a weekly skin inspection. A review of R3's medical record lacked indication R3 had or refused a weekly skin assessment from 11/14/22- 12/14/22. When interviewed on 12/13/22, at 12:20 p.m. nursing assistant (NA)-A stated when residents have a bath or shower, the nurse was notified right before the resident was dressed to complete a skin assessment. If a resident refused the bath nurses had to be notified so a skin check was still completed.	2 900		

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2 900	Continued From page 5 When interviewed on 12/13/22, at 12:40 p.m. registered nurse (RN)-A stated weekly skin assessments were required for residents when showers or baths were completed. Nursing assistants notified nurses when the bath was completed, and the resident was ready for the skin assessment. RN-A stated if residents refused a bath, the nurse had to still complete a skin assessment during that time. If the resident refused a skin assessment the nurse should re-approach a few times. RN-A further stated the weekly skin assessment had to be documented even if the resident refused. RN-A verified R1, R2, and R3 were at risk for pressure injuries and R1, R2, and R3's medical records lacked weekly skin assessments. RN-A further stated R1 and R3 were able to make their needs known and were known to refuse cares at times, but the refusal should have been documented. R2 was on hospice care and the hospice aid helps with bathing. RN-A stated even with hospice support, the weekly skin assessment was still required. When interviewed on 12/13/22, at 2:56 p.m. the Director of Nursing (DON) stated a skin assessment was completed upon admission and then weekly assessments were completed on the resident's bath day. DON expected the weekly skin assessments to be completed even if the resident refused a bath. Furthermore, staff were expected to document any resident refusal of skin assessments. DON verified R1, R2, and R3's missing weekly skin assessments. DON stated completing weekly skin assessments for residents was important to identify new skin concerns. Early identification was important so interventions or treatment could be started. A facility policy titled Skin Assessment and Wound Management dated 7/2018, directed	2 900		

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2 900	Continued From page 6 residents will have a weekly skin assessment by a licensed staff. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person could review policies and procedures for weekly skin assessments, educate staff and monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900		