Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2024

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: May 22, 2024

Dear Administrator:

On July 24, 2024, we notified you a remedy was imposed. On August 27, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 21, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 8, 2024 be discontinued as of August 21, 2024. (42 CFR 488.417 (b))

In our letter of July 24, 2024, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 8, 2024. 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,

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

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September 3, 2024

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Re: Reinspection Results
Event ID: OW0212, 9DXT12, and FRMP12

Dear Administrator:

On July 24, 2024, August 12, 2024, and August 27, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspections of your facility, to determine correction of orders found on the surveys completed on May 22, 2024, July 11, 2024, and August 8, 2024. 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
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July 24, 2024

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: CCN: 245255
Cycle Start Date: May 22, 2024

Dear Administrator:

On June 10, 2024, we informed you that we may impose enforcement remedies.

On July 11, 2024, the Minnesota Department of Health completed a survey 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 constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 8, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 8, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 8, 2024.

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 $12,924, 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 August 8, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Cerenity Care Center On Humboldt will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 8, 2024. 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:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 November 22, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@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 Steven.Delich@cms.hhs.gov.

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

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

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

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

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
	245255	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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 7/10/24 -7/11/24, 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 complaints were reviewed. H52555504C MN104762 with no deficiences issues The following complaints were reviewed. H52555484C MN104692/104790 with a deficiency issued at F641, F684 & 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to accurately assess 1 of 3 residents (R1) reviewed upon admission to the facility. R1 was	F 641	Plan of Correction Components: Statement of credible allegation (can use	8/7/24

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

Electronically Signed | 07/26/2024

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 641	Continued From page 1 admitted with two pressure ulcers, a deep tissue injury and a shearing wound that the facility did not assess or create inventions for during his stay at the facility. R1's hospital discharge orders dated 6/25/24 indicated R1 had: -A Stage 3 (an injury that extends through the skin into deeper skin and fat but does not reach muscle tendon or bone) pressure ulcer on the dorsum (upper surface) of his second right toe. R1 had this pressure injury since 1/6/23. -A dermatologic condition of his right foot since 1/6/23 -Incision on the anterior portion of his right knee since 6/20/24 -A Stage 4 (an injury that extends to the muscle, tendon, and bone) pressure injury on the dorsum of his third right toe since 6/21/24. -A dermatologic condition of generalized rash and pruritis since 6/21/24 -A Shearing wound to his buttocks bilaterally from friction and adhesive from sacral Mepilex (a wound dressing) since 6/21/24. -A deep tissue pressure injury (when there is not an open wound, but the tissues beneath surface have been damaged the skin may appear purple or dark red) to R1's right thigh since 6/24/24. -A Peripheral inserted central catheter (PICC) single lumen permanent tunneled and implanted to his left chest placement 6/25/25. R1's skin assessment dated 6/24/24 at 7:10 p.m. indicated R1 was always continent of bowel. R1 had a rash in his peri-care, no description documented. The assessment indicated R1 did not have one or more unhealed pressure injuries at a Stage 1 or higher. R1 did have an open lesion on his foot and a surgical wound. No	F 641	in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F641: Accuracy of Assessments 1. R1 discharged on 7/8/24 and is no longer residing in the facility. 2. All residents at high risk for developing skin impairment according to their Braden score have the potential to be affected. Residents at high risk for skin impairment have been audited to determine assessment accuracy, and that the care plan addresses interventions related to skin. 3. MDS coordinator was educated in reviewing hospital information and community observations. Nurses have been educated on completing full skin assessment upon admission and developing skin care plan interventions. 4. All admissions will be audited for 4 weeks to ensure skin conditions are assessed accurately, and skin care plans	

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F 641	Continued From page 2 description information was documented. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered	F 641	were developed, then 2 admissions audited per week for 4 weeks, then 1 admission audited per week for 4 weeks. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. 5. Date of compliance is 08/07/2024.	

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F 641	Continued From page 3 -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds. R1's care plan failed to document problem, goals, and an approach for R1's pressure ulcers of the toes, potential for pressure ulcers per Braden assessment, turning and reposition and how R1 was to toilet, transfer, and what assistance was required for activities of daily living. R1's Braden Scale for Prediction of Pressure Sore Risk dated 7/1/24 indicated: -R1's sensory perception was completely limited, R1 was unresponsive to painful stimuli. -R1 was constantly moist - skin is kept moist constantly by perspiration, urine etc. Dampness is detected every time resident is moved or turned. -R1 was chairfast. -R1 was completely immobile - does not make slight changes in body or extremity position without assistance. -R1's nutrition was probably inadequate. -R1 had a problem with friction and shearing - He required moderate to maximum assistance in moving. -R1's Braden score was eight. Indicated very high risk for pressure ulcers. R1's interventions were: -Pressure reducing device for chair and bed. -Turning/repositioning program. -Nutrition for hydration intervention to manage skin problems. The assessment failed to provide interventions	F 641		

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F 641	Continued From page 4 for pressure ulcer care, application of nonsurgical dressings, application of ointments or applications of dressing. No other measures were taken. R1's admission Minimum Data Set (MDS) dated 7/2/24 indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, "his skin was not good." She stated R1 was incontinent of bowel and bladder and often had diarrhea, making R1's skin "red, raw, and bleeding on his buttocks." She stated she believed the nursing staff was aware of his skin concerns because he had a zinc treatment the nursing assistants were applying to his back and buttocks. NA-A stated she recalled R1 had some kind of dressing on his toes but was not aware whether nursing was doing a treatment or not.	F 641		

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F 641	Continued From page 5 Upon interview on 7/10/24 at 4:15 p.m. NA-C stated R1 had diarrhea often and his "bottom and back" had rashes "all over" that were bleeding from multiple "open areas." She stated that the nursing department was aware because they would assist NA-C to change R1 and clean him when he was incontinent. She stated R1 would cry whenever the skin on his back was touched. Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she was not aware R1 had any wounds. She stated the nursing manager had mentioned R1 had some yeast in his groin and asked for Nystatin powder and the order was given. She stated R1's family member, (FM)-A called her and spoke with her about the groin rash and about his back. FM-A was asking if an acetic acid treatment that the hospital did, with good results, could be implemented for the rash and sores on R1's back. The NP told FM-A she would look into that treatment. FM-A also inquired with the NP about using a hydrocortisone cream on his skin. The NP stated that she wanted hydrocortisone applied to his entire body for itching. The NP ordered hydrocortisone to be used on itching areas, she was not aware where R1's itchy areas were. The NP denied ever observing R1's skin stating the facility staff does the skin observations and reports concerns to her or refers the residents directly to wound care. Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated R1 did not admit with any wounds. She stated a "few" days after admission R1's FM-A was asking about using acetic acid on his back however RN-A stated R1 did not have any rash or redness. RN-A stated she was not aware of the documented wounds on the hospital	F 641		

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F 641	Continued From page 6 discharge. She stated the wounds were more than likely overlooked because there were no orders attached to them from the hospital. RN-A was uncertain why R1's care plan indicated wound care to see R1 weekly since he did not have wounds. RN-A stated he was not seen by wound care because the provider was on vacation on 7/3/24 and the provider the agency sent out to the facility, did not seen R1 on that date and R1 was discharged on 7/8/24. Upon interview on 7/11/24 at 1:53 p.m. RN-B the Resident Assessment Instrument (RAI) coordinator stated she was aware that R1 had some shearing on his buttocks, surgical sutures and a PICC line. She stated she was not aware of any other wounds. RN-B stated she does not observe residents directly when completing her assessments, she goes by what the staff has documented. Upon interview on 7/11/24 at 2:09 p.m. licensed practical nurse (LPN)-A, Infection Preventionist stated she added to R1's care the intervention for wound care to see R1 weekly. She stated the reason was because he had a surgical wound with known infections. She was not aware of any other wounds. Upon interview on 7/11/24 at 3:30 p.m. RN-C stated he completed R1's admission skin assessment. He stated he recalled R1 had, what appeared to be, a couple of open blisters that had popped on two of R1's toes. He stated due to shoulder pain and inability to turn RN-C was unable to assess R1's backside to assess. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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 641	Continued From page 7 of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing to observe the patient and if a nurse can assess a resident fully to notify the manager so the staff can get an accurate assessment later. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the RAI tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Prevention and treatment of skin breakdown dated 2018 indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care.	F 641		
F 684 SS=G	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 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.	F 684		8/7/24

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F 684	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to comprehensively assess and follow the hospital discharge orders to keep a cast completely dry for 1 of 3 residents (R1) reviewed for orders. R1 was harmed when he was admitted to the facility with a post-surgical cast covering his right leg with orders that the cast must remain dry, and the facility failed to keep the cast dry. R1 was sent to the hospital where the cast was found to be soiled with urine and feces, contributing to continuous infections. Findings include: R1's hospital discharge information to the facility dated 6/25/24 indicated R1 was medically complicated. R1 had a right knee open reduction dislocated hinged total knee arthroplasty revision on 6/20/24 with confirmation of infectious bacteria: staphylococcus aureus and pseudomonas aeruginosa. Following the lab results R1 underwent placement of a peripherally inserted central catheter (PICC) line to directly treat the bacteria infections with antibiotics. R1 had a history chronic and multiple episodes of bacteremia: methicillin-susceptible staphylococcus aureus (MSSA), group B strep, pseudomonas aeruginosa, corynebacterium, and s. epidermidis. of the right infected total knee prosthesis dating back to 2020. R1's active problem list also included atrial fibrillation, cardiomyopathy ischemic, coronary artery disease, chronic kidney disease stage 4, obesity, presence of automatic cardiac defibrillator with pacemaker, declined functional status, delirium, history of right fractured ankle with open reduction and internal fixation (ORIF) 2021 and	F 684	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F684: Quality of Care R1 discharged on 7/8/24 and is no longer residing in the facility. All residents admitted to the facility have the potential to be affected. The facility will ensure that the residents are comprehensively assessed, hospital discharge orders were followed on any residents with non-removable devices, and the care plan has appropriate interventions. Admissions from the last 30 days have been reviewed to ensure that they were comprehensively assessed, hospital discharge orders were followed on all residents with a non-removable device, and the care plan has appropriate interventions.	

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F 684	Continued From page 9 left knee arthroplasty total knee replacement 2021, history of left shoulder arthroscopy date unknown with a current views on 6/19/24 indicating the surgical components appeared intact. R1 had history of falling, deep vein thrombosis, anemia, anxiety, obstructive sleep apnea. R1's hospital after visit summary dated 6/26/24 indicated R1's knee incision was covered by a long leg cast. Do not put anything under the cast. Keep the cast completely dry. R1 was to maintain the long leg cast until a return appointment on 7/9/24. Do not let cast get wet, if does get wet, notify the orthopedic surgeon immediately. R1's skin assessment dated 6/24/24 at 7:10 p.m. indicated R1 was always continent of bowel. No intervention of bowel care was initiated on the care plan. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray	F 684	All nurses have been educated on ensuring a comprehensive assessment of new admissions has been completed and that appropriate skin interventions are in place. Nurses have also been educated on following hospital discharge orders on all residents with a non-removable device. All nursing assistants have been educated on reporting skin alterations to a licensed nurse. All admission will be audited for 4 weeks, then 2 admissions audited per week for 4 weeks, then 1 admission audited per week for 4 weeks to ensure completion of comprehensive assessments, skin care plan interventions were put in place, and hospital discharge orders were being followed on all residents with a non-removable device. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Date of compliance is 08/07/2024.	

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F 684	Continued From page 10 results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds. R1's care plan failed to document problem, goals, and an approach for R1's toileting, transferring, and what assistance was required for activities of daily living. R1's care plan failed to assess whether R1 was to wear an incontinent pad or not or if he were to use the urinal by himself. In addition, R1's care plan did not identify that R1's cast was to kept dry and methods to keep it dry. R1's admission Minimum Data Set (MDS) dated	F 684		

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F 684	Continued From page 11 7/2/24 indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Progress note dated 7/5/24 at 8:58 a.m. indicated: R1 had a covered cast on his right knee, no drainage noted. R1 had dull pain of his right knee. R1's toileting was dependent. R1's skin condition was not assessed. Emergency room encounter 7/7/24 at 8:51 p.m. indicated R1 was an 82-year-old male with multiple medical problems from a facility with failure to thrive, decreased mental status and fatigue. Recently R1 was discharged from another hospital after he was found to have an infected right total knee replacement. R1's groin was red and irritated with no signs of Fournier's gangrene. His cast was soaked in the upper and half due to urine. His left lower extremity was all bandaged and specifically a dorsal wound of the	F 684		

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F 684	Continued From page 12 third toe which appears to be infected. Posteriorly R1 had Stage II (partial loss of skin, but no deeper than the dermis) pressure ulceration on his essentially backside from the mid-thigh through the mid lumbosacral (five large vertebrae that make-up the lumbar portion of the spine) region. R1 will be sent to larger hospital where he had surgery for further care as well as treatment. Emergency room nursing note dated 7/7/24 at 11:48 p.m. R1 came in looking red, flush, and complaining of pain. Upon skin assessment staff noticed the following: -Red, swollen skin to the scrotum, penis and peri-area, penis had a large amount of smegma (thick cheesy secretion around genital that collects when not washed regularly). -Skin around R1's cast on the right leg was excoriated, red and non-blanchable and cast was noted to have a strong odor to it along with being saturated with urine and stool. -Left arm had a cast stocking on it from the hand to midway past the elbow, damp and visually soiled. Hospital admission note dated 07/08/24 at 12:00 p.m. indicated R1 presented with septic shock secondary from infected right knee on 7/8/24. His dressing was removed by orthopedics and noted significant soiling of the dressing with concern for infection of the knee. R1 was transferred to the intensive care unit (ICU) for continuing care on 7/9/24. Orthopedic surgeon was planning a washout vs. amputation of R1's right leg. Infectious disease summary 7/8/24 indicated on admission R1 was found to have fecal and urine	F 684		

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F 684	Continued From page 13 contamination of his right knee incisions under the cast. His incisions were noted to be macerated (a softening and breaking down of skin resulting from prolonged exposure to moisture) and dehiscence (separation of wound edges). He was also noted to have foul smelling drainage. Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, stated R1 was incontinent of bowel and bladder and often had diarrhea. R1's urinal would spill under him because he would leave I between his legs and fall asleep. Staff checked on him every two hours, but when he was finished using the urinal, he would not press the call light when he was finished with the urinal. NA-A stated no other means of toileting was attempted. Upon interview on 7/10/24 at 3:23 p.m. Family member (FM)-A stated R1 arrived at the large regional hospital and was awaiting amputation of his right leg. She stated at the emergency room (ER) R1's cast was cut off due to the odor and then staff found the entire cast was seeping with urine and feces. FM-A stated the ER noticed the infected surgical knee sight and immediately notified the hospital where he had surgery and wanted him sent back due to their ability to handle infections of "that level." FM-A stated she noted the smell of urine and feces in his room and noticed the top cloth portion of the cast was yellow with urine. She stated the facility did not speak with her about interventions other than a urinal to keep him dry. The facility did not drape anything over the cast, discuss a catheter or make an attempt to stop his diarrhea. Upon interview on 7/10/24 at 4:01 p.m.	F 684		

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F 684	Continued From page 14 occupation therapist, (OT)-A stated she was only saw R1 on one occasion and that was the day after his admission when she completed her assessment. She stated she attempted to sit R1 at the edge of his bed and he became incontinent of "very runny" stool. Cleaning him required the assistance of the nursing assistants. She stated she does not recall the stool getting on his cast, but did not see how it could not, as he had to be laid down in bed and rolled to be cleaned. She stated she was aware that R1 used a urinal for urination and stated it was right of the family to choose the method they prefer. She stated occupation therapist assistant (OTA)-A told her R1 frequently had his urinal between his legs, and it would spill. OT-A stated she did not do another assessment on R1's safe use of a urinal. She stated nursing would be more likely to do that as they do the bowel and bladder assessment. OT-A stated R1 had been incontinent of bowel and bladder since his day of admission to the facility. Upon interview on 7/10/24 at 4:41 p.m. R1's orthopedic surgeon stated, in a few moments R1 was going to have his right leg amputated above his knee. He stated, "I can't say 100% that the urine and feces filled cast caused the infection requiring amputation, but it certainly had a contributing factor." Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she did not notice any odor or urine on R1's cast. She stated that the facility did not reach out to her and ask for a catheter or any other invention, such as a barrier cover. She stated having R1 use a urinal with a cast within inches of R1's right groin and a dislocated left shoulder was not a good plan for a	F 684		

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F 684	Continued From page 15 cast needing to stay dry. She stated she was not aware R1 was having diarrhea therefor no interventions were ordered. Upon interview on 7/11/24 at 11:10 a.m. R1's occupation therapy aide (OTA)-A stated she did notice "frequently" when she went to work with R1 that he had a urinal between his legs and his bedding was soiled. She stated she did not notice the cast was soiled. She stated on the 7/7/24 she assisted the nursing assistants with cleaning R1 after an episode of diarrhea. She stated that the feces did get on the cast and cast was yellow tingled from urine. Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated that she was aware that R1 used a urinal, she was not aware of any spillage from the use. She denied staff ever reporting that the cast had gotten soiled if it did the surgeon would have been called immediately. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing and treating the residents to follow the resident's orders. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the resident assessment instrument (RAI) tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Abuse Prevention Plan Prevention dated 2017 indicated neglect is the failure of the facility, its employees, or services	F 684		

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F 684	Continued From page 16 providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent 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 record review the facility failed to ensure 1 of 3 residents (R1) reviewed for pressure ulcers received care consistent with professional standards of practice to prevent pressure or worsening of pre-admission pressure ulcers. R1 was harmed when the facility failed to promote healing of current pressure ulcers and prevent new ulcers from developing. R1 was admitted with two pressure ulcers, and a shearing wound on 6/26/26. R1 discharged from the facility on 7/7/14 with three pressure ulcers and the shearing wound turned into stage II pressure ulcers in multiple areas from his thigh to his mid-dorsal back.	F 686	Plan of Correction Components: Statement of credible allegation (can use in MN, WI, MO) This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or	8/7/24

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F 686	Continued From page 17 R1's hospital discharge information to the facility dated 6/25/24 indicated R1 was medically complicated. R1 had a right knee open reduction dislocated hinged total knee arthroplasty revision on 6/20/24 with confirmation of infectious bacteria: staphylococcus aureus and pseudomonas aeruginosa. Following the lab results R1 underwent placement of a peripherally inserted central catheter (PICC) line to directly treat the bacteria infections with antibiotics. R1 had a history chronic and multiple episodes of bacteremia: methicillin-susceptible staphylococcus aureus (MSSA), group B strep, pseudomonas aeruginosa, corynebacterium, and s. epidermidis. of the right infected total knee prosthesis dating back to 2020. R1's active problem list also included atrial fibrillation, cardiomyopathy ischemic, coronary artery disease, chronic kidney disease stage 4, obesity, presence of automatic cardiac defibrillator with pacemaker, declined functional status, delirium, history of right fractured ankle with open reduction and internal fixation (ORIF) 2021 and left knee arthroplasty total knee replacement 2021, history of left shoulder arthroscopy date unknown with a current views on 6/19/24 indicating the surgical components appeared intact. R1 had history of falling, deep vein thrombosis, anemia, anxiety, obstructive sleep apnea. R1's hospital discharge orders dated 6/25/24 indicated R1 had: -A Stage 3 (an injury that extends through the skin into deeper skin and fat but does not reach muscle tendon or bone) pressure ulcer on the dorsum (upper surface) of his second right toe. R1 had this pressure injury since 1/6/23. -A dermatologic condition of his right foot since	F 686	executed in accordance with federal and state law requirements. F686: Treatment/Services to prevent/heal pressure ulcers 1. R1 discharged on 7/8/24 and is no longer residing in the facility. 2. All residents at high risk for developing skin impairment according to their Braden score have the potential to be affected. Facility will review all current residents with an at-risk Braden score to ensure that residents have interventions in place to promote healing and prevent new ulcers from developing. 3. All nurses will be educated on the development of care plan interventions to promote healing of pressure ulcers and prevent new ones. All nurse managers will be educated on continuing to review and further develop skin care plans. 4. Skin interventions will be audited on all new admissions for 4 weeks, then 2 admissions per week for 4 weeks, then 1 admission per week for 4 weeks. Audit results will be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. 5. Date of compliance is 08/07/2024.	

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F 686	Continued From page 18 1/6/23 -Incision on the anterior portion of his right knee since 6/20/24 -A Stage 4 (an injury that extends to the muscle, tendon, and bone) pressure injury on the dorsum of his third right toe since 6/21/24. -A dermatologic condition of generalized rash and pruritis since 6/21/24 -A Shearing wound to his buttocks bilaterally from friction and adhesive from sacral Mepilex (a wound dressing) since 6/21/24. -A deep tissue pressure injury (when there is not an open wound, but the tissues beneath surface have been damaged the skin may appear purple or dark red) to R1's right thigh since 6/24/24. -A Peripheral inserted central catheter (PICC) single lumen permanent tunneled and implanted to his left chest placement 6/25/25. R1's after visit summary dated 6/26/24 indicated on 10/27/22 - present for R1's dermatitis perianal was to include acetic acid soaks for 15 minutes followed by zinc oxide keeping the area open and dry. R1's skin assessment dated 6/24/24 at 7:10 p.m. indicated R1 was always continent of bowel. R1 had a rash in his peri-care, no description documented. The assessment indicated R1 did not have one more unhealed pressure injuries at a Stage 1 or higher. R1 did have an open lesion on his foot and a surgical wound, no description documented. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV	F 686		

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CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 686	Continued From page 19 bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed.	F 686		

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F 686	Continued From page 20 -Wound team to follow on weekly rounds. R1's care plan dated 6/27/24 did not indicate R1 had any pressure ulcers. In addition, R1's care plan failed to document problem, goals, and an approach for R1's pressure ulcers of the toes, potential for pressure ulcers per Braden assessment, turning and reposition and how R1 was to toilet, transfer, and what assistance was required for activities of daily living. R1's care plan failed to assess whether R1 was to wear an incontinent pad or not or if he were to use the urinal by himself. R1's Braden Scale for Prediction of Pressure Sore Risk dated 7/1/24 indicated: -R1's sensory perception was completely limited, R1 was unresponsive to painful stimuli. -R1 was constantly moist - skin is kept moist constantly by perspiration, urine etc. Dampness is detected every time resident is moved or turned. -R1 was chairfast. -R1 was completely immobile - does not make slight changes in body or extremity position without assistance. -R1's nutrition was probably inadequate. -R1 had a problem with friction and shearing - He required moderate to maximum assistance in moving. R1's Braden score was eight. Indicated very high risk for pressure ulcers. R1's interventions were: -Pressure reducing device for chair and bed. -Turning/repositioning program. -Nutrition for hydration intervention to manage skin problems. The assessment failed to provide interventions for pressure ulcer care, application of nonsurgical dressings, application of ointments or applications	F 686		

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F 686	Continued From page 21 of dressing. No other measures were taken, and the care plan was not updated. R1's admission Minimum Data Set (MDS) dated 7/2/24 indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Progress note dated 7/5/24 at 8:58 a.m. indicated: R1 had a covered cast on his right knee, no drainage noted. R1 had dull pain of his right knee. R1's toileting was dependent. R1's skin condition was not assessed. R1's nursing progress note dated 7/5/25 at 10:17 a.m. R1's family member (FM)-A was in the facility taking pictures of R1's skin. FM-A started placing acetic acid to skin on R1's buttocks and told the NA she was going to leave it on for 1 hour. FM-A stated this was the order that the hospital was performing. LPN-A attempted to	F 686		

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F 686	Continued From page 22 education FM-A that an hour was too long. FM-A stated this is the only way the redness will improved. FM-A stated that R1's bottom was very red, sore, and bleeding in areas where the skin is excoriated or "split open". LPN-A observed the skin the prior day and the skin was red and intact. FM-A also asked when R1 had his last oxycodone (a narcotic pain medication) as FM-A felt R1 was too sedated. R1 had not received any oxycodone since 7/2/24 at 2:00 p.m. FM-A did not want R1 to receive any more oxycodone, but also stated R1 was in so much pain because of his bottom hurt him. LPN-A explained R1 will not lay in bed on his side, he sits in a chair or lies on his back and the skin does not get any relief. FM-A stated that the staff are not making him lie on his side. LPN-A stated the staff cannot make him change position. LPN-A called the primary care clinic triage and left a message for the NP regarding pain management and informed her that FM-A was doing acetic acid treatments and leaving on the skin for a longer period that was order. The progress note did not indicate a description of R1's skin on 7/5/25 just the prior day observation or what the facility was doing for the R1's skin. Emergency room encounter 7/7/24 at 8:51 p.m. indicated R1 was an 82-year-old male with multiple medical problems from a facility with failure to thrive, decreased mental status and fatigue. Recently R1 was discharged from a regional hospital after he was found to have an infected right total knee replacement. R1's groin was red and irritated with no signs of Fournier's gangrene. His cast was soaked in the upper and half due to urine. His left lower extremity was all bandaged and specifically a dorsal wound of the third toe which appears to be infected.	F 686		

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F 686	Continued From page 23 Posteriorly R1 had Stage II (partial loss of skin, but no deeper than the dermis) pressure ulceration on his essentially backside from the mid-thigh through the mid lumbosacral (five large vertebrae that make-up the lumbar portion of the spine) region. R1 will be sent back to the reginal larger hospital where he had surgery for further care as well as treatment. Emergency room nursing note dated 7/7/24 at 11:48 p.m. R1 came in looking red, flush, and complaining of pain. Upon skin assessment staff noticed the following: -Red, non-blanchable, grossly excoriated, bleeding skin of the gluteus maximus, gluteus Medius, and gluteus minimus. -Red, swollen skin to the scrotum, penis and peri-area, penis had a large amount of smegma (thick cheesy secretion around genital that collects when not washed regularly). -Red excoriated skin to the right abdominal folds and right axillary. -Skin around R1's cast on the right leg was excoriated, red and non-blanchable and cast was noted to have a strong odor to it along with being saturated with urine and stool. -Left thigh, knee and shin aberrations from leg rubbing on the cast. -Left arm had a cast stocking on it from the hand to midway past the elbow, damp and visually soiled. -Left top of foot had an open sore weeping serosanguinous drainage. Hospital admission note dated 07/08/24 at 12:00 p.m. indicated: #1 Wound 07/08/24 Incontinence Associated Dermatitis Buttocks and posterior thighs.	F 686		

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F 686	Continued From page 24 Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Incontinence Associated Dermatitis Location: Buttocks Wound Description (Comments): and posterior thighs Shape Irregular *Wound Bed Open; Red; Shiny Tissue Exposed None Odor None Exudate Amount Small Drainage Description Serosanguineous Peri-wound Assessment Fragile ;Friable; Painful; Rash #2 Wound 07/08/24 Incontinence Associated Dermatitis Groin Bilateral and thighs. Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Incontinence Associated Dermatitis Location: Groin Wound Location Orientation: Bilateral Wound Description: and thighs Shape Irregular *Wound Bed Closed; Red; Shiny Odor None Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Friable; Painful; Red; Rash #3 Wound 07/08/24 Intertriginous Dermatitis Pannus Right Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Intertriginous Dermatitis Location: Pannus Wound Location Orientation: Right Shape Irregular *Wound Bed Closed; Red; Shiny Odor None Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Fragile; Red; Rash	F 686		

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F 686	Continued From page 25 #4 Wound 07/08/24 Intertriginous Dermatitis Axilla Bilateral Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Intertriginous Dermatitis Location: Axilla Wound Location Orientation: Bilateral Shape Irregular *Wound Bed Closed; Red; Shiny Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Maceration; Rash #5 Wound 06/21/24 Pressure Injury Stage 4 Toe Third Left; Dorsum Date First Assessed/Time First Assessed: 06/21/24 1020 Primary Wound Type: Pressure Injury Pressure Injury Staging: Stage 4 Location: Toe Third Wound Location Orientation: Left; Dorsum Shape Round / oval *Wound Bed Full thickness; Red; Yellow Tissue Exposed Bone Odor None Exudate Amount Small Drainage Description Sanguineous Peri-wound Assessment Intact #6 Wound 01/06/23 Pressure Injury Stage 3 Toe 2nd Right; Dorsum Date First Assessed/Time First Assessed: 01/06/23 1315 Primary Wound Type: Pressure Injury Pressure Injury Staging: Stage 3 Location: Toe 2nd Wound Location Orientation: Right; Dorsum Shape Irregular *Wound Bed Red; Pink; Open Odor None Exudate Amount Scant Drainage Description Serosanguineous Peri-wound Assessment Maceration	F 686		

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F 686	Continued From page 26 Wound 07/08/24 Pressure Injury Deep Tissue Heel Right #7 wound Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Pressure Injury Pressure Injury Staging: Deep tissue Location: Heel Wound Location Orientation: Right Shape Round / oval *Wound Bed Black; Brown; Pink (mixed wound bed, evolving purple discoloration with sloughing edges revealing pink tissue) Tissue Exposed None Odor None Exudate Amount Scant Drainage Description Serosanguineous Peri-wound Assessment Fragile Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, "his skin was not good." She stated R1 was incontinent of bowel and bladder and often had diarrhea, making R1's skin "red, raw, and bleeding on his buttocks." Sometimes he would have an incontinence pad on and sometimes he would not, if he were having frequent diarrhea, staff would put an incontinent pad on and if not, staff would let him sit without an incontinence pad. She stated she believed the nursing staff was aware of R1's skin concerns because he had a zinc treatment the nursing assistants were applying to his back and buttocks. NA-A stated she recalled R1 had some kind of dressing on his toes but was not aware whether nursing was doing a treatment or not. R1 used the urinal on his own and with staff assistance. The urinal would spill under R1 as he would leave the urinal between his legs and fall asleep. The urine would spill on his skin and his cast. Staff checked on him every two hours, but when he was finished using the urinal, he would	F 686		

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F 686	Continued From page 27 not press the call light for assistance. Upon interview on 7/10/24 at 3:23 p.m. FM-A stated she visited R1 almost daily and she would find him incontinent of urine or stool. She stated R1 was not to have an incontinent pad on because his skin was to be open to air and she would often find him wearing one. She stated she left notes all over R1's room for what staff was to do for his skin care. She stated the staff was supposed to be doing an acetic acid treatment on his buttock and back. The facility told FM-A they did not have an order. FM-A called the nurse practitioner (NP) and told her R1's skin was getting worse, and she wanted the staff to follow the hospital recommendations. FM-A did not receive a response from the NP. She stated she took the acetic acid that he that hospital staff had used and started doing the cares herself. FM-A stated R1 was difficult to reposition, because of the dislocation to his left shoulder. She stated she would perform his repositioning by shifting him slightly with a pillow under one side of his buttocks to relieve pressure. She stated she asked staff to reposition him that way multiple times with no avail. FM-A asked an unidentified nursing assistant why R1 was wearing a pad and to please remove it and clean him as the pad was wet. The response FM-A received was, if he is wet, he did not need to be changed until the line on the pad turned blue. FM-A removed the pad herself and cleaned R1. Upon interview on 7/10/24 at 4:15 p.m. NA-C stated R1 had diarrhea often and his "bottom and back" had rashes "all over" that were bleeding from multiple "open areas." She stated that the nursing department was aware because they	F 686		

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F 686	Continued From page 28 would assist NA-C to change R1 and clean him when he was incontinent. R1 would cry whenever the skin on his back was touched. NA-C would sometimes find R1 in an incontinent brief and sometimes not she stated there were not specific instructions on that. She stated if staff did not put an incontinent brief on R1 they would have entire bed changes due to either urine or feces. Upon interview on 7/10/24 at 4:41 p.m. R1's orthopedic surgeon stated, "the condition of R1's skin when he returned to the hospital from the facility was neglect." He stated please read all the hospital wound notes from his hospital discharge summary on 6/26/24 to his re-admission note on 7/8/24. Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she was not aware R1 had any wounds. She stated the nursing manager had mentioned R1 had some yeast in his groin and asked for Nystatin powder and the order was given. She stated R1's family member, (FM)-A had called her and spoke with her about the groin rash and about his back. FM-A was asking if an acetic acid treatment that the hospital did, with good results, could be implemented for the rash and sores on R1's back. The NP told FM-A she would investigate that treatment. FM-A also inquired with the NP about using a hydrocortisone cream on his skin. The NP stated that the daughter wanted hydrocortisone applied to his entire body for itching. The NP ordered hydrocortisone to be used on itching areas, she was not aware where R1's itchy areas were. The NP denied ever observing R1's skin stating the facility staff makes observations and reports concerns to her or refers the residents directly to the wound care.	F 686		

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F 686	Continued From page 29 Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated R1 did not admit with any wounds. She stated a "few" days after admission R1's daughter was asking about using acetic acid on his back however he did not have any rash or redness. RN-C stated she was not aware of the documented wounds on the hospital discharge. Acetic acid was listed on the discharge medication list and RN-A stated she thought that was maybe from a catheter he may have had. RN-A did not find out exactly what the acetic acid was recommended for. She stated the wounds were more than likely overlooked because there were no orders attached to them. RN-C was uncertain why R1's care plan indicated wound care to see R1 weekly since he did not have wounds. RN-A stated he was not seen by wound care because the provider was on vacation on 7/3/24 and the provider the agency sent out, did not seen R1 on that date and R1 was discharged on 7/8/24. RN-A did not observe R1's skin directly during his stay. Upon interview on 7/11/24 at 3:30 p.m. RN-C stated he completed R1's admission skin assessment. He stated he recalled R1 had what appeared to be a couple of open blisters that had popped on two of R1's toes. He stated due to shoulder pain and inability to turn RN-C was unable to assess R1's backside to assess. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing to observe the patient and if a nurse can assess a resident fully to notify the manager so the staff can get an	F 686		

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F 686	Continued From page 30 accurate assessment later. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the RAI tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Prevention and treatment of skin breakdown dated 2018 indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care.	F 686		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 24, 2024

Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Re: State Nursing Home Licensing Orders
Event ID: 9DXT11

Dear Administrator:

The above facility was surveyed on July 10, 2024 through July 11, 2024 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:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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
	00538	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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
2 000	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 7/10/24 - 7/11/24, 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	2 000		

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

Electronically Signed | 07/26/24

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H52555504C MN104762 The following complaints were reviewed. H52555484C (MN104692/104790 with licensing orders issued at ST0540 & ST0900 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	2 000		

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2 000	Continued From page 2 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.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition;	2 540		8/7/24

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2 540	Continued From page 3 J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to accurately assess 1 of 3 residents (R1) reviewed upon admission to the facility. R1 was admitted with two pressure ulcers, a deep tissue injury and a shearing wound that the facility did not assess or create inventions for during his stay at the facility. R1's hospital discharge orders dated 6/25/24 indicated R1 had: -A Stage 3 (an injury that extends through the skin into deeper skin and fat but does not reach muscle tendon or bone) pressure ulcer on the dorsum (upper surface) of his second right toe. R1 had this pressure injury since 1/6/23. -A dermatologic condition of his right foot since 1/6/23. -Incision on the anterior portion of his right knee since 6/20/24 -A Stage 4 (an injury that extends to the muscle, tendon, and bone) pressure injury on the dorsum of his third right toe since 6/21/24. -A dermatologic condition of generalized rash and pruritis since 6/21/24 -A Shearing wound to his buttocks bilaterally from friction and adhesive from sacral Mepilex (a wound dressing) since 6/21/24. -A deep tissue pressure injury (when there is not an open wound, but the tissues beneath surface have been damaged the skin may appear purple or dark red) to R1's right thigh since 6/24/24. -A Peripheral inserted central catheter (PICC)	2 540	Corrected	

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2 540	Continued From page 4 single lumen permanent tunneled and implanted to his left chest placement 6/25/25. R1's skin assessment dated 6/24/24 at 7:10 p.m. indicated R1 was always continent of bowel. R1 had a rash in his peri-care, no description documented. The assessment indicated R1 did not have one or more unhealed pressure injuries at a Stage 1 or higher. R1 did have an open lesion on his foot and a surgical wound. No description information was documented. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake	2 540		

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2 540	Continued From page 5 -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds. R1's care plan failed to document problem, goals, and an approach for R1's pressure ulcers of the toes, potential for pressure ulcers per Braden assessment, turning and reposition and how R1 was to toilet, transfer, and what assistance was required for activities of daily living. R1's Braden Scale for Prediction of Pressure Sore Risk dated 7/1/24 indicated: -R1's sensory perception was completely limited, R1 was unresponsive to painful stimuli. -R1 was constantly moist - skin is kept moist constantly by perspiration, urine etc. Dampness is detected every time resident is moved or turned. -R1 was chairfast. -R1 was completely immobile - does not make slight changes in body or extremity position without assistance. -R1's nutrition was probably inadequate. -R1 had a problem with friction and shearing - He required moderate to maximum assistance in	2 540		

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2 540	Continued From page 6 moving. -R1's Braden score was eight. Indicated very high risk for pressure ulcers. R1's interventions were: -Pressure reducing device for chair and bed. -Turning/repositioning program. -Nutrition for hydration intervention to manage skin problems. The assessment failed to provide interventions for pressure ulcer care, application of nonsurgical dressings, application of ointments or applications of dressing. No other measures were taken. R1's admission Minimum Data Set (MDS) dated 7/2/24 indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, "his skin was not good." She stated R1 was incontinent of bowel and bladder and often had diarrhea, making R1's skin "red, raw, and bleeding on his buttocks." She	2 540		

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2 540	Continued From page 7 stated she believed the nursing staff was aware of his skin concerns because he had a zinc treatment the nursing assistants were applying to his back and buttocks. NA-A stated she recalled R1 had some kind of dressing on his toes but was not aware whether nursing was doing a treatment or not. Upon interview on 7/10/24 at 4:15 p.m. NA-C stated R1 had diarrhea often and his "bottom and back" had rashes "all over" that were bleeding from multiple "open areas." She stated that the nursing department was aware because they would assist NA-C to change R1 and clean him when he was incontinent. She stated R1 would cry whenever the skin on his back was touched. Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she was not aware R1 had any wounds. She stated the nursing manager had mentioned R1 had some yeast in his groin and asked for Nystatin powder and the order was given. She stated R1's family member, (FM)-A called her and spoke with her about the groin rash and about his back. FM-A was asking if an acetic acid treatment that the hospital did, with good results, could be implemented for the rash and sores on R1's back. The NP told FM-A she would look into that treatment. FM-A also inquired with the NP about using a hydrocortisone cream on his skin. The NP stated that she wanted hydrocortisone applied to his entire body for itching. The NP ordered hydrocortisone to be used on itching areas, she was not aware where R1's itchy areas were. The NP denied ever observing R1's skin stating the facility staff does the skin observations and reports concerns to her or refers the residents directly to wound care. Upon interview on 7/11/24 at 11:53 a.m. RN-A the	2 540		

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2 540	Continued From page 8 unit manager stated R1 did not admit with any wounds. She stated a "few" days after admission R1's FM-A was asking about using acetic acid on his back however RN-A stated R1 did not have any rash or redness. RN-A stated she was not aware of the documented wounds on the hospital discharge. She stated the wounds were more than likely overlooked because there were no orders attached to them from the hospital. RN-A was uncertain why R1's care plan indicated wound care to see R1 weekly since he did not have wounds. RN-A stated he was not seen by wound care because the provider was on vacation on 7/3/24 and the provider the agency sent out to the facility, did not seen R1 on that date and R1 was discharged on 7/8/24. Upon interview on 7/11/24 at 1:53 p.m. RN-B the Resident Assessment Instrument (RAI) coordinator stated she was aware that R1 had some shearing on his buttocks, surgical sutures and a PICC line. She stated she was not aware of any other wounds. RN-B stated she does not observe residents directly when completing her assessments, she goes by what the staff has documented. Upon interview on 7/11/24 at 2:09 p.m. licensed practical nurse (LPN)-A, Infection Preventionist stated she added to R1's care the intervention for wound care to see R1 weekly. She stated the reason was because he had a surgical wound with known infections. She was not aware of any other wounds. Upon interview on 7/11/24 at 3:30 p.m. RN-C stated he completed R1's admission skin assessment. He stated he recalled R1 had, what appeared to be, a couple of open blisters that had popped on two of R1's toes. He stated due to	2 540		

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2 540	Continued From page 9 shoulder pain and inability to turn RN-C was unable to assess R1's backside to assess. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing to observe the patient and if a nurse can assess a resident fully to notify the manager so the staff can get an accurate assessment later. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the RAI tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Prevention and treatment of skin breakdown dated 2018 indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION:	2 540		

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2 540	Continued From page 10 Twenty-One (21) days.	2 540		
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 record review the facility failed to ensure 1 of 3 residents (R1) reviewed for pressure ulcers received care consistent with professional standards of practice to prevent pressure or worsening of pre-admission pressure ulcers. R1 was harmed when the facility failed to promote healing of current pressure ulcers and prevent new ulcers from developing. R1 was admitted with two pressure ulcers, and a shearing wound on 6/26/26. R1 discharged from the facility on 7/7/14 with three pressure ulcers and the shearing wound turned into stage II pressure ulcers in multiple areas from his thigh to his mid-dorsal back.	2 900	Corrected	8/7/24

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2 900	Continued From page 11 R1's hospital discharge information to the facility dated 6/25/24 indicated R1 was medically complicated. R1 had a right knee open reduction dislocated hinged total knee arthroplasty revision on 6/20/24 with confirmation of infectious bacteria: staphylococcus aureus and pseudomonas aeruginosa. Following the lab results R1 underwent placement of a peripherally inserted central catheter (PICC) line to directly treat the bacteria infections with antibiotics. R1 had a history chronic and multiple episodes of bacteremia: methicillin-susceptible staphylococcus aureus (MSSA), group B strep, pseudomonas aeruginosa, corynebacterium, and s. epidermidis. of the right infected total knee prosthesis dating back to 2020. R1's active problem list also included atrial fibrillation, cardiomyopathy ischemic, coronary artery disease, chronic kidney disease stage 4, obesity, presence of automatic cardiac defibrillator with pacemaker, declined functional status, delirium, history of right fractured ankle with open reduction and internal fixation (ORIF) 2021 and left knee arthroplasty total knee replacement 2021, history of left shoulder arthroscopy date unknown with a current views on 6/19/24 indicating the surgical components appeared intact. R1 had history of falling, deep vein thrombosis, anemia, anxiety, obstructive sleep apnea. R1's hospital discharge orders dated 6/25/24 indicated R1 had: -A Stage 3 (an injury that extends through the skin into deeper skin and fat but does not reach muscle tendon or bone) pressure ulcer on the dorsum (upper surface) of his second right toe. R1 had this pressure injury since 1/6/23. -A dermatologic condition of his right foot since	2 900		

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2 900	Continued From page 12 1/6/23 -Incision on the anterior portion of his right knee since 6/20/24 -A Stage 4 (an injury that extends to the muscle, tendon, and bone) pressure injury on the dorsum of his third right toe since 6/21/24. -A dermatologic condition of generalized rash and pruritis since 6/21/24 -A Shearing wound to his buttocks bilaterally from friction and adhesive from sacral Mepilex (a wound dressing) since 6/21/24. -A deep tissue pressure injury (when there is not an open wound, but the tissues beneath surface have been damaged the skin may appear purple or dark red) to R1's right thigh since 6/24/24. -A Peripheral inserted central catheter (PICC) single lumen permanent tunneled and implanted to his left chest placement 6/25/25. R1's after visit summary dated 6/26/24 indicated on 10/27/22 - present for R1's dermatitis perianal was to include acetic acid soaks for 15 minutes followed by zinc oxide keeping the area open and dry. R1's skin assessment dated 6/24/24 at 7:10 p.m. indicated R1 was always continent of bowel. R1 had a rash in his peri-care, no description documented. The assessment indicated R1 did not have one more unhealed pressure injuries at a Stage 1 or higher. R1 did have an open lesion on his foot and a surgical wound, no description documented. R1's admission nursing progress note dated 6/26/24 at 10:37 p.m. indicated R1 arrived from the hospital and had knee replacement surgery. R1 had a cast on his right leg. R1 had a PICC line on his upper left chest area. R1 had some IV bruises on his right arm and wounds on his left	2 900		

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2 900	Continued From page 13 foot 2nd and 3rd toe. R1 had a slight rash on his bottom and some blood. He had a spot near top of his cast. [sic] R1's care plan dated 6/27/24 indicated R1 had an infection in his right knee wound culture results were Staphylococcus Aureus and Pseudomonas. R1's risk factors were a history of Pseudomonas in wounds and inadequate fluid intake. R1 admitted with an infection, abnormal wound drainage, abnormal labs, and abnormal x-ray results. R1's goal was to resolve the infection without signs or symptoms of complications of antibiotics. R1's approaches were: -Antibiotics per medical provider, monitor for effectiveness and side effects -Assess for pain: nature, intensity, location, and duration -Encourage periods of rest -Encourage high protein/high carbohydrate foods/fluids when indicated -Encourage oral fluid intake -Explore with resident potential etiological factors, which potentiate infection and include appropriate health teaching. -Isolation precautions per policy - Enhanced barrier precautions -IV as ordered, IV dressing change and site care as ordered -Labs as ordered -Meds as ordered -Monitor for signs and symptoms of worsening infection -Monitor vital signs every shift for duration of antibiotic therapy -Observe for any complications with IV therapy: signs of infection around site, infiltration -Update family and medical provider as needed. -Wound team to follow on weekly rounds.	2 900		

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2 900	Continued From page 14 R1's care plan dated 6/27/24 did not indicate R1 had any pressure ulcers. In addition, R1's care plan failed to document problem, goals, and an approach for R1's pressure ulcers of the toes, potential for pressure ulcers per Braden assessment, turning and reposition and how R1 was to toilet, transfer, and what assistance was required for activities of daily living. R1's care plan failed to assess whether R1 was to wear an incontinent pad or not or if he were to use the urinal by himself. R1's Braden Scale for Prediction of Pressure Sore Risk dated 7/1/24 indicated: -R1's sensory perception was completely limited, R1 was unresponsive to painful stimuli. -R1 was constantly moist - skin is kept moist constantly by perspiration, urine etc. Dampness is detected every time resident is moved or turned. -R1 was chairfast. -R1 was completely immobile - does not make slight changes in body or extremity position without assistance. -R1's nutrition was probably inadequate. -R1 had a problem with friction and shearing - He required moderate to maximum assistance in moving. R1's Braden score was eight. Indicated very high risk for pressure ulcers. R1's interventions were: -Pressure reducing device for chair and bed. -Turning/repositioning program. -Nutrition for hydration intervention to manage skin problems. The assessment failed to provide interventions for pressure ulcer care, application of nonsurgical dressings, application of ointments or applications of dressing. No other measures were taken, and the care plan was not updated.	2 900		

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2 900	Continued From page 15 R1's admission Minimum Data Set (MDS) dated 7/2/24 indicated R1 had a Brief Interview for Mental Status (BIMs) score of 15 indicating R1 was cognitively intact. R1 required extensive assistant for bed mobility, transferring, eating and toilet use. The MDS indicated R1 had no unhealed pressure ulcers or injuries. R1 was occasionally incontinent of urine and frequently incontinent of bowel. R1 had a surgical wound. His skin treatments were pressure reducing device for chair and bed and applications of ointments. The MDS did not indicate turning/repositioning program, nutrition or hydration interventions or pressure ulcer care. R1's pertinent diagnoses were Methicillin susceptible Staphylococcus aureus infection, Pseudomonas, presence of right artificial knee joint, lymphedema (swelling caused by lymphatic blockage), atopic dermatitis (itchy inflammation of the skin), pain in right knee, infection, and inflammatory reaction due to internal right knee prosthesis. Progress note dated 7/5/24 at 8:58 a.m. indicated: R1 had a covered cast on his right knee, no drainage noted. R1 had dull pain of his right knee. R1's toileting was dependent. R1's skin condition was not assessed. R1's nursing progress note dated 7/5/25 at 10:17 a.m. R1's family member (FM)-A was in the facility taking pictures of R1's skin. FM-A started placing acetic acid to skin on R1's buttocks and told the NA she was going to leave it on for 1 hour. FM-A stated this was the order that the hospital was performing. LPN-A attempted to education FM-A that an hour was too long. FM-A stated this is the only way the redness will improved. FM-A stated that R1's bottom was very red, sore, and bleeding in areas where the skin is	2 900		

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2 900	Continued From page 16 excoriated or "split open". LPN-A observed the skin the prior day and the skin was red and intact. FM-A also asked when R1 had his last oxycodone (a narcotic pain medication) as FM-A felt R1 was too sedated. R1 had not received any oxycodone since 7/2/24 at 2:00 p.m. FM-A did not want R1 to receive any more oxycodone, but also stated R1 was in so much pain because of his bottom hurt him. LPN-A explained R1 will not lay in bed on his side, he sits in a chair or lies on his back and the skin does not get any relief. FM-A stated that the staff are not making him lie on his side. LPN-A stated the staff cannot make him change position. LPN-A called the primary care clinic triage and left a message for the NP regarding pain management and informed her that FM-A was doing acetic acid treatments and leaving on the skin for a longer period that was order. The progress note did not indicate a description of R1's skin on 7/5/25 just the prior day observation or what the facility was doing for the R1's skin. Emergency room encounter 7/7/24 at 8:51 p.m. indicated R1 was an 82-year-old male with multiple medical problems from a facility with failure to thrive, decreased mental status and fatigue. Recently R1 was discharged from a regional hospital after he was found to have an infected right total knee replacement. R1's groin was red and irritated with no signs of Fournier's gangrene. His cast was soaked in the upper and half due to urine. His left lower extremity was all bandaged and specifically a dorsal wound of the third toe which appears to be infected. Posteriorly R1 had Stage II (partial loss of skin, but no deeper than the dermis) pressure ulceration on his essentially backside from the mid-thigh through the mid lumbosacral (five large vertebrae that make-up the lumbar portion of the	2 900		

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2 900	Continued From page 17 spine) region. R1 will be sent back to the reginal larger hospital where he had surgery for further care as well as treatment. Emergency room nursing note dated 7/7/24 at 11:48 p.m. R1 came in looking red, flush, and complaining of pain. Upon skin assessment staff noticed the following: -Red, non-blanchable, grossly excoriated, bleeding skin of the gluteus maximus, gluteus Medius, and gluteus minimus. -Red, swollen skin to the scrotum, penis and peri-area, penis had a large amount of smegma (thick cheesy secretion around genital that collects when not washed regularly). -Red excoriated skin to the right abdominal folds and right axillary. -Skin around R1's cast on the right leg was excoriated, red and non-blanchable and cast was noted to have a strong odor to it along with being saturated with urine and stool. -Left thigh, knee and shin aberrations from leg rubbing on the cast. -Left arm had a cast stocking on it from the hand to midway past the elbow, damp and visually soiled. -Left top of foot had an open sore weeping serosanguinous drainage. Hospital admission note dated 07/08/24 at 12:00 p.m. indicated: #1 Wound 07/08/24 Incontinence Associated Dermatitis Buttocks and posterior thighs. Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Incontinence Associated Dermatitis Location: Buttocks Wound Description (Comments): and posterior thighs Shape Irregular *Wound Bed Open; Red; Shiny	2 900		

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2 900	Continued From page 18 Tissue Exposed None Odor None Exudate Amount Small Drainage Description Serosanguineous Peri-wound Assessment Fragile ;Friable; Painful; Rash #2 Wound 07/08/24 Incontinence Associated Dermatitis Groin Bilateral and thighs. Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Incontinence Associated Dermatitis Location: Groin Wound Location Orientation: Bilateral Wound Description: and thighs Shape Irregular *Wound Bed Closed; Red; Shiny Odor None Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Friable; Painful; Red; Rash #3 Wound 07/08/24 Intertriginous Dermatitis Pannus Right Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Intertriginous Dermatitis Location: Pannus Wound Location Orientation: Right Shape Irregular *Wound Bed Closed; Red; Shiny Odor None Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Fragile; Red; Rash #4 Wound 07/08/24 Intertriginous Dermatitis Axilla Bilateral Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Intertriginous Dermatitis Location: Axilla Wound Location Orientation: Bilateral Shape Irregular *Wound Bed Closed; Red; Shiny	2 900		

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2 900	Continued From page 19 Exudate Amount Scant Drainage Description Serous Peri-wound Assessment Maceration; Rash #5 Wound 06/21/24 Pressure Injury Stage 4 Toe Third Left; Dorsum Date First Assessed/Time First Assessed: 06/21/24 1020 Primary Wound Type: Pressure Injury Pressure Injury Staging: Stage 4 Location: Toe Third Wound Location Orientation: Left; Dorsum Shape Round / oval *Wound Bed Full thickness; Red; Yellow Tissue Exposed Bone Odor None Exudate Amount Small Drainage Description Sanguineous Peri-wound Assessment Intact #6 Wound 01/06/23 Pressure Injury Stage 3 Toe 2nd Right; Dorsum Date First Assessed/Time First Assessed: 01/06/23 1315 Primary Wound Type: Pressure Injury Pressure Injury Staging: Stage 3 Location: Toe 2nd Wound Location Orientation: Right; Dorsum Shape Irregular *Wound Bed Red; Pink; Open Odor None Exudate Amount Scant Drainage Description Serosanguineous Peri-wound Assessment Maceration Wound 07/08/24 Pressure Injury Deep Tissue Heel Right #7 wound Date First Assessed: 07/08/24 Present on Original Admission: Yes, Primary Wound Type: Pressure Injury Pressure Injury Staging: Deep tissue Location: Heel Wound Location Orientation: Right Shape Round / oval *Wound Bed	2 900		

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2 900	Continued From page 20 Black; Brown; Pink (mixed wound bed, evolving purple discoloration with sloughing edges revealing pink tissue) Tissue Exposed None Odor None Exudate Amount Scant Drainage Description Serosanguineous Peri-wound Assessment Fragile Upon interview on 7/10/24 at 10:41 a.m. nursing assistant, (NA)-A stated, "his skin was not good." She stated R1 was incontinent of bowel and bladder and often had diarrhea, making R1's skin "red, raw, and bleeding on his buttocks." Sometimes he would have an incontinence pad on and sometimes he would not, if he were having frequent diarrhea, staff would put an incontinent pad on and if not, staff would let him sit without an incontinence pad. She stated she believed the nursing staff was aware of R1's skin concerns because he had a zinc treatment the nursing assistants were applying to his back and buttocks. NA-A stated she recalled R1 had some kind of dressing on his toes but was not aware whether nursing was doing a treatment or not. R1 used the urinal on his own and with staff assistance. The urinal would spill under R1 as he would leave the urinal between his legs and fall asleep. The urine would spill on his skin and his cast. Staff checked on him every two hours, but when he was finished using the urinal, he would not press the call light for assistance. Upon interview on 7/10/24 at 3:23 p.m. FM-A stated she visited R1 almost daily and she would find him incontinent of urine or stool. She stated R1 was not to have an incontinent pad on because his skin was to be open to air and she would often find him wearing one. She stated she left notes all over R1's room for what staff	2 900		

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2 900	Continued From page 21 was to do for his skin care. She stated the staff was supposed to be doing an acetic acid treatment on his buttock and back. The facility told FM-A they did not have an order. FM-A called the nurse practitioner (NP) and told her R1's skin was getting worse, and she wanted the staff to follow the hospital recommendations. FM-A did not receive a response from the NP. She stated she took the acetic acid that he that hospital staff had used and started doing the cares herself. FM-A stated R1 was difficult to reposition, because of the dislocation to his left shoulder. She stated she would perform his repositioning by shifting him slightly with a pillow under one side of his buttocks to relieve pressure. She stated she asked staff to reposition him that way multiple times with no avail. FM-A asked an unidentified nursing assistant why R1 was wearing a pad and to please remove it and clean him as the pad was wet. The response FM-A received was, if he is wet, he did not need to be changed until the line on the pad turned blue. FM-A removed the pad herself and cleaned R1. Upon interview on 7/10/24 at 4:15 p.m. NA-C stated R1 had diarrhea often and his "bottom and back" had rashes "all over" that were bleeding from multiple "open areas." She stated that the nursing department was aware because they would assist NA-C to change R1 and clean him when he was incontinent. R1 would cry whenever the skin on his back was touched. NA-C would sometimes find R1 in an incontinent brief and sometimes not she stated there were not specific instructions on that. She stated if staff did not put an incontinent brief on R1 they would have entire bed changes due to either urine or feces. Upon interview on 7/10/24 at 4:41 p.m. R1's	2 900		

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2 900	Continued From page 22 orthopedic surgeon stated, "the condition of R1's skin when he returned to the hospital from the facility was neglect." He stated please read all the hospital wound notes from his hospital discharge summary on 6/26/24 to his re-admission note on 7/8/24. Upon interview on 7/11/24 at 10:43 a.m. R1's nurse practitioner (NP) stated she was not aware R1 had any wounds. She stated the nursing manager had mentioned R1 had some yeast in his groin and asked for Nystatin powder and the order was given. She stated R1's family member, (FM)-A had called her and spoke with her about the groin rash and about his back. FM-A was asking if an acetic acid treatment that the hospital did, with good results, could be implemented for the rash and sores on R1's back. The NP told FM-A she would investigate that treatment. FM-A also inquired with the NP about using a hydrocortisone cream on his skin. The NP stated that the daughter wanted hydrocortisone applied to his entire body for itching. The NP ordered hydrocortisone to be used on itching areas, she was not aware where R1's itchy areas were. The NP denied ever observing R1's skin stating the facility staff makes observations and reports concerns to her or refers the residents directly to the wound care. Upon interview on 7/11/24 at 11:53 a.m. RN-A the unit manager stated R1 did not admit with any wounds. She stated a "few" days after admission R1's daughter was asking about using acetic acid on his back however he did not have any rash or redness. RN-C stated she was not aware of the documented wounds on the hospital discharge. Acetic acid was listed on the discharge medication list and RN-A stated she thought that was maybe from a catheter he may have had.	2 900		

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2 900	Continued From page 23 RN-A did not find out exactly what the acetic acid was recommended for. She stated the wounds were more than likely overlooked because there were no orders attached to them. RN-C was uncertain why R1's care plan indicated wound care to see R1 weekly since he did not have wounds. RN-A stated he was not seen by wound care because the provider was on vacation on 7/3/24 and the provider the agency sent out, did not seen R1 on that date and R1 was discharged on 7/8/24. RN-A did not observe R1's skin directly during his stay. Upon interview on 7/11/24 at 3:30 p.m. RN-C stated he completed R1's admission skin assessment. He stated he recalled R1 had what appeared to be a couple of open blisters that had popped on two of R1's toes. He stated due to shoulder pain and inability to turn RN-C was unable to assess R1's backside to assess. Upon interview on 7/11/24 at 3:42 p.m. the director of nursing, (DON) stated her expectation of staff would be for the NAs to report any skin concerns to the nurses. She stated she expected nursing staff who are assessing to observe the patient and if a nurse can assess a resident fully to notify the manager so the staff can get an accurate assessment later. Upon interview on 7/11/24 at 3:55 p.m. the Administrator stated her expectation would be for the RAI tool to be accurate, leading to an accurate care plan for the residents and finally proper care being implemented for the residents. A facility policy titled Prevention and treatment of skin breakdown dated 2018 indicated resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 24 completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900		