Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 29, 2024

Administrator
Maplewood Rehabilitation Center
1900 Sherren Avenue East
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: April 29, 2024

Dear Administrator:

On May 28, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 29, 2024

Administrator
Maplewood Rehabilitation Center
1900 Sherren Avenue East
Maplewood, MN 55109

Re: Reinspection Results
Event ID: 9OG112

Dear Administrator:

On May 28, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 29, 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
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 6, 2024

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: April 29, 2024

Dear Administrator:

On April 29, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 29, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 29, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by

the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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Electronically delivered
May 6, 2024

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: 9OG111

Dear Administrator:

The above facility was surveyed on April 25, 2024 through April 29, 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:

Lisa Krebs, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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
	245276	A. BUILDING _____ B. WING _____	C 04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD REHABILITATION CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

(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 4/25/24 and 4/29/24, 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 complaint was reviewed: H52763391C (MN00102743) with a deficiency cited at F684. 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 684	R2's wounds were added to weekly	5/23/24

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

Electronically Signed | 05/13/2024

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F 684	Continued From page 1 review, the facility failed to monitor edema and comprehensively assess non-pressure related wounds for 1 of 1 resident (R2) reviewed. Findings Include: R2's admission Minimum Data Set (MDS) dated 2/25/24, indicated R2 was admitted on 2/19/24 with diagnoses including malignant neoplasm of brain (brain cancer), hypertension, and chronic ischemic heart disease (weakening of the heart caused by reduced blood flow) and was receiving hospice care. R2's active physician order dated 2/19/24, directed nurses to chart R2's condition in nurse's notes every shift for edema (fluid retention in body tissues that can result in swelling and/or weight gain) checks noting edema as present or not present and lung checks noting lungs as clear or not clear. R2's treatment administration records (TAR) were reviewed in conjunction with progress notes and skin evaluations, it was not evident edema was consistently comprehensively evaluated. Although the TAR's which identified the physician orders for edema checks and lung sounds were completed, the extent of edema was not included. Instead the TAR for edema monitoring documentation had plus signs (+) indicating edema was present or minus signs (-) indicating no edema. In the boxes for lung sounds the boxes identified (cl) for clear and (+) for not clear. R2's active physician order dated 2/19/24, directed staff to complete weekly weights for R2 every Thursday.	F 684	wound rounds. R2's Hospice provider perscribed new orders for Edema monitoring and parameters. R2's Hospice provider perscribed new orders for weights. As all residents have a chance to be affected by this, full house audit completed. All effected and like residents were audited and updated for diagnosis of Edema, Edema treatment orders updated as needed, Edema related monitoring orders updated as needed. DON to review previous day skin checks, daily, to ensure measurements for all skin integrity concerns are included. Facility to add all new open skin concerns to weekly wound rounds. DON/ADON to coordinate education for all nurse staff for skin integrity to ensure comprehensive skin assessments are taking place. Facility will monitor all new residents upon admission x3weeks, 3 admissions x3weeks, 1 admission x3weeks. The facility will monitor 12 residents with Edema interventions x3weeks, 6 residents with Edema interventions x3weeks, and 4 residents with Edema interventions x3weeks. The results of these audits will be shared with the facility QAPI committee for inputs on need to increase or decrease or discontinue audits. DON/ADON to complete facility audits.	

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F 684	Continued From page 2	F 684		

R2's weight record was reviewed in conjunction with progress notes and skin evaluations, R2's weight record identified between 2/19/24 to 4/25/24, R2 had a weight gain of 16.2 pounds (lbs). It was not evident R2's weight gains were comprehensively assessed to ascertain if the gains were nutritional and/or fluid related in order to evaluate for a change in R2's overall health status and possible disease progression and further treatment needs.

Weights documented in R2's electronic health record (EHR) included:
181.4 pounds (lbs.) on 4/25/24 at 2:34 p.m.
181.4 lbs. on 4/25/24 at 12:48 p.m.
177.2 lbs. on 4/18/24 at 1:58 p.m.
177.2 lbs. on 4/18/24 at 1:55 p.m.
177.2 lbs. on 4/18/24 at 1:52 p.m.
180.8 lbs. on 4/11/24 at 2:47 p.m.
180.8 lbs. on 4/11/24 at 1:59 p.m.
181.0 lbs. on 4/4/24 at 2:56 p.m.
181.0 lbs. on 4/4/24 at 12:28 p.m.
182.4 lbs. on 3/28/24 at 12:18 p.m.
182.4 lbs. on 3/28/24 at 10:13 p.m.
177.4 lbs. on 3/21/24 at 1:44 p.m.
177.4 lbs. on 3/21/24 at 12:40 p.m.
176.6 lbs. on 3/14/24 at 8:59 p.m.
176.6 lbs. on 3/14/24 at 2:00 p.m.
176.6 lbs. 3/14/24 at 9:33 a.m.
175.4 lbs. on 3/7/24 at 1:59 p.m.
175.4 lbs. on 3/7/24 at 1:36 p.m.
171.4 lbs. on 2/29/24 at 2:49 p.m.
171.4 lbs. on 2/29/24 at 1:30 p.m.
169.6 lbs. on 2/22/24 at 10:42 a.m.
169.6 lbs. on 2/22/24 at 10:21 a.m.
165.2 lbs. on 2/19/24 at 2:20 p.m.
165.2 lbs. on 2/19/24 at 12:49 p.m.
165.2 lbs. on 2/19/24 at 12:32 p.m.

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F 684	Continued From page 3 A provider note dated 2/21/24, from R2's initial encounter indicated "due to progressive functional and cognitive decline, oncology recommended transition to hospice. He is admitted here for LTC [long term care] on [agency name] hospice." It also noted R2 reported he quite smoking 39 years ago and his smoking use included cigarettes. R2's Weekly Skin Inspection dated 2/22/24, noted R2 had large bruises on his left inner and outer elbow and a scar, bruising on bilateral lower extremities (BLE, both legs), a scar on the left shin, and scratches on knees and shin. It did not note any other skin concerns or edema. R2's Skin Evaluation and Skin Risk Factors assessment dated 2/23/24, noted R2 had a left antecubital (inner elbow) skin tear, bruising on the left elbow, scar on the left elbow, and identified a skin issue on the left forearm but did not specify what type of issue. The description and summary sections noted R2 had a large superficial skin tear on his left forearm and an unspecified wound bed looked red. Drainage was listed as N/A, the periwound description and measurements were not completed. Risk factors selected from a pre-populated list of options were psychotropic drug use. R2's hypertension, cancer, history of smoking, left side hemiparesis, and cognitive impairment were not identified. The summary indicated R2 had no feeling on the left side as he said his left side upper and lower extremities are numb. No interventions were listed in the interventions section. R2's Wound Evaluation Form dated 2/23/24, noted a left forearm skin tear that was superficial with a red wound bed. A dressing was applied to	F 684		

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F 684	Continued From page 4 the wound bed and covered with a gauze, no pain was associated with wound care. The measurements section was not completed. No additional Wound Evaluation Forms were identified during review of R2's EHR. A hospice communication note date 2/26/24, indicated wound care was completed for the left arm and included the following measurements of unspecified wounds: 4 x 2.5 centimeters (cm), 2.5 x 2 cm, 1 x 1 cm, 1 x 0.5 cm, and 1 x 0.5 cm. Information about the specific wound locations, types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's Weekly Skin Inspection dated 2/29/24, bruising on the left elbow, arm, and back of left hand, some scars and skin tears, bruising and scars on the back of the right hand, bruising on BLE, and signs of edema on both feet. Information about the specific wound locations, wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. Assessment of the edema was also not documented. A hospice communication note dated 3/1/24, indicated wound cares were completed on the left arm and included measurements of 4.5 x 1.5 cm outer left forearm wound, 2 x 1.5 cm inner left forearm wound, 1 x 1 cm elbow wound, and 1 x 1 and 0.5 x 0.5 cm wounds on the bottom of the left arm. Information about the wound types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A hospice communication note dated 3/5/24,	F 684		

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F 684	Continued From page 5 indicated wound care was performed and included wound measurements of 3 x 2 cm, 0.5 x 1 cm, and 1 x 1 cm on the left top arm and 2 x 2 cm, 0.5 x 0.5 cm, and 1 x 1 cm on the left bottom arm. Information about the specific wound locations, wound types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's active physician order dated 3/7/24, directed staff to apply Velcro wraps (compression wraps) to BLE. R2's Weekly Skin Inspection dated 3/7/24, noted R3 had bruising on "BLU" (possible mis-type of BUE, bilateral upper extremities) and BLE with scars. It did not identify any edema or further skin issues. A hospice communication note dated 3/8/24, indicated wound care was performed. No information about the wounds was documented. A hospice communication note dated 3/11/24, indicated wound cares were completed on the left arm, four of five wounds were resolved, and included a measurement of 0.8 x 1 cm of a wound on [illegible] left forearm. Information about the wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 3/12/24, noted a 30-day nutritional review was completed by dietary and identified a weight of 175.4 lbs. on 3/7/24, weight gain noted since admission, family and hospice updated, registered dietician will continue to observe per facility protocol.	F 684		

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F 684	Continued From page 6 A progress note dated 3/12/24, noted R2 said he was going through a door and squeezed his left arm against the door, sustaining a skin tear on the left elbow. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's care plan identified a risk for alteration in skin integrity related to frail skin, left-sided hemiparesis (one-sided muscle weakness), and weakness dated 3/13/24. Interventions included application of a geri-sleeve (sleeve to protect fragile skin) to left and right arms covering R2's hands, forearms, and elbows to prevent skin tears/abrasions, inspection of skin daily with nursing aides to report any concerns to nurse, and weekly skin assessment by licensed staff. R2's skin care plan did not identify his edema or included related interventions. R2's Skin Evaluation and Skin Risk Factors assessment dated 3/13/24, identified a left elbow skin tear. The wound bed was described as approximated edges with steri-strips (adhesive bandages) applied. It noted the periwound area (skin surrounding the wound) was intact and the wound bled a small amount at first with no further drainage. The presence of a new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were cognitive impairment and other: left side hemiparesis. R2's psychotropic drug use, hypertension, cancer, and history of smoking were not identified. Interventions included R2 wearing a geri-sleeve on the left arm. The summary described the incident causing the skin tear.	F 684		

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MAPLEWOOD REHABILITATION CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

(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 684	Continued From page 7 R2's Weekly Skin Inspection dated 3/14/24, noted bruising on bilateral upper extremities (BUE) with wounds in healing on the left arm and scars as well as bruising on BLE. Information about the number and location of the wounds on the left arm, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema. A progress note dated 3/15/24, noted a new small skin tear with a scab forming on the left forearm was identified while resident's geri-sleeve was removed for a shower. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A hospice communication note dated 3/15/24, indicated wound care was completed for the left arm. Information about the number and location of the wound(s) on the left arm, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's Skin Evaluation and Skin Risk Factors assessment dated 3/15/24, noted skin tears on the left elbow and left forearm. The wound bed noted steri-strips on the left elbow skin tear and a small skin tear on the left forearm with a scab forming and Band-Aid applied. Drainage description noted scant blood but did not identify the associated wound(s). The periwound area was described as intact with no open areas. The presence of a new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were cognitive impairment, psychotropic drug use, and other: left	F 684		

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	245276	A. BUILDING _____ B. WING _____	C 04/29/2024

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F 684	Continued From page 8 side hemiparesis. R2's hypertension, cancer, and history of smoking were not identified. Interventions included geri-sleeve on left arm, wheelchair cushion, and an extended wheelchair arm rest for the left side requested from hospice. Information about the wound measurements and pain was not documented. A hospice communication note dated 3/19/24, indicated wound care was completed for the left leg and left arm. It noted "left leg is new, unsure cause but appears vascular due to edema." Information about the extent of the edema was not identified. Furhter the number and location of the wounds, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's Weekly Skin Inspection dated 3/21/24, noted bruising on BUE with scars on the back of both hands and open wounds on the left elbow, bruising on BLE, scars and a wound on the left shin, and bruising on the left side of the neck. Information about the number and location of the wound(s) on the left elbow, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema. A hospice communication note dated 3/21/24, indicated wound care was completed, there was no complaint of pain, no signs or symptoms of infection, and included the following measurements: 1.5 x 1 cm left lateral arm wound, 3 x 2 cm left arm wound, and 1 x 0.5 cm left leg wound. Information about the wound beds, drainage, odor, periwound area and wound	F 684		

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F 684	Continued From page 9 edges, and risk factors was not documented. A progress note dated 3/22/24, noted assessment was done of the right leg due to the weekly skin check indicating the presence of a wound. No wound or open area was noted, a small intact scab was identified. A hospice communication note dated 3/25/24, indicated wound care was completed on the left leg and arm. It noted "several new wound[s] to left arm, will reassess on next visit for measurements." Information about the specific location of the wounds, measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's active physician order dated 3/25/24, directed that R2 take 4 milligrams (mg) of dexamethasone (a steroid medication) by mouth once daily. R2's Weekly Skin Inspection dated 3/28/24, noted bruising on BUE with scars, an open area on the left forearm, bruising on the right lower extremity, and small scab on the right lower shin. Information about the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema. R2's Fall from Chair report dated 3/28/24, noted R2 fell and sustained injuries including bleeding from the left elbow at the site of a previous injury, and a skin tear in the inner upper arm. The left elbow injury was identified as a skin tear. Information about the measurements, wound beds, drainage, odor, periwound area and wound	F 684		

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F 684	Continued From page 10 edges, risk factors, and pain was not documented. A progress note dated 3/31/24, noted R2 was found on the floor and sustained skin tears on the right arm and left hand. Information about the specific of the right arm wound, wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 3/31/24, noted the on-call provider ordered monitoring of R2's skin tears. R2's Weekly Skin Inspection dated 4/4/24, noted bruising and scars on BUE, right lower extremity bruising, and a scab on the right shin. It did not identify edema. R2's Weekly Skin Inspection dated 4/11/24, noted bruising and scars on BUE, multiple bruises on the left arm, bruising on the right lower extremity, and a superficial scratch on the right thigh. It did not identify edema. A progress note dated 4/12/24, noted R2 bumped his hand on the toilet grab bar when sitting down and sustained a skin tear on the right hand. Information about the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's Skin Evaluation and Skin Risk Factors assessment dated 4/12/24, noted a skin tear on the back of the right hand. The description noted it was superficial with a wound bed of 100% epithelial tissue, drainage was a small amount of bleeding, and the periwound area had peeled skin	F 684		

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F 684	Continued From page 11 around the edges of the wound. A new wound prompting assessment was marked yes. Risk factors identified included other: hemiplegia and frail skin. R's psychotropic drug use, steroid medication, hypertension, cancer, history of smoking, and cognitive impairment were not identified. No interventions were identified. R2's Weekly Skin Inspection dated 4/18/24, noted bruising and scars on BUE, a scar on the right thigh, and some small bruising on the right lower extremity. It did not identify edema and noted there were no other skin issues at the time. A Fall Review Evaluation dated 4/20/24, noted R2 fell in the bathroom and no injury was found. A progress note dated 4/22/24, noted the inter-disciplinary team reviewed R2's fall on 4/20/24 and R2 had a small, scabbed area on his right posterior arm related to the fall. It did not include further assessment of the newly identified scabbed area. A progress noted dated 4/22/24, noted R2 had a skin tear on his right arm close to the elbow and the nurse manager was notified. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 4/24/24, noted R2 obtained a skin tear on 4/24/24 and had fragile skin and was at high risk for skin tears. Information about the specific wound location, wound measurements, wound bed, drainage, odor, periwound area and wound edges, specific risk factors, and pain was not documented.	F 684		

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F 684	Continued From page 12 R2's Skin Evaluation and Skin Risk Factors assessment dated 4/24/24, listed left elbow skin tear injury. The wound beds were described as superficial with a red periwound area. The summary noted R2 had two open area on his left elbow that looked superficial. The drainage section was not complete. A new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were psychotropic drug use. R2's steroid medication, cognitive impairment, hemiparesis, hypertension, cancer, and history of smoking were not identified. No interventions were identified. Information about wound drainage, odor, pain, and measurements was not documented. R2's Weekly Skin Inspection dated 4/25/24, noted wounds on the left elbow and bruising, bruising and a wound on the right forearm, and bruising on the left lower extremity. Information about the specific number and location of the left elbow wounds, measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. No edema was identified. A hospice communication note dated 4/25/24, indicated wound care was completed on the "Lt. FA [left forearm?]," there was stinging afterwards, and R2 took a dose of as needed Tylenol. Information about the number of wounds, wound measurements, wound beds, drainage, odor, periwound area and wound edges, and risk factors was not documented. R2's Treatment Administration Record (TAR) included the active physician order for edema	F 684		

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F 684	Continued From page 13 checks. Charting from the day shift on 4/29/24 noted no edema was present. During an observation on 4/29/24 at 10:22 a.m., R2's feet were examined with registered nurse (RN)-A. RN-A stated R2's right foot was swollen with pitting edema measuring 2+ to 3+ (edema that leaves a dimple after being pressed is pitting and is measured by depth of indention from 1+ most shallow to 4+ deepest) that extended up to his ankle. RN-A stated R2's left foot had pitting edema of 1+ on the inner side and 2+ on the left side extending up to his ankle. RN-A stated R2 had a history of edema and staff put socks and Velcro wraps on him every day and checked his feet and edema at this time. RN-A indicated that she would complete a progress note if edema was noted or, on shower days, a skin check was completed and she would include the edema in that documentation. RN-A stated if a nurse saw edema they would document it and include if it was trace edema, pitting edema, and the grade. During an interview on 4/29/24 at 10:26 a.m., R2 stated he wore the Velcro sleeves on his legs to help with the swelling and before he wore them his skin was swelling up so much it was breaking open. R2 stated the swelling was present for at least the last six months in both of his feet and he wore the Velcro sleeves every day. In an interview on 4/29/24 at 11:08 a.m., the director of nursing (DON) stated edema is monitored through daily observation from the aides who would notify the nurse of any concerns. The DON stated nurses also observe residents when they give medications and complete weekly skin checks. The DON noted the weekly skin checks should say if edema was noted and if it	F 684		

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F 684	Continued From page 14 was pitting and the grade. The DON stated that if it was not the day of the week for the weekly skin check then edema would be documented in a progress note. The DON stated R2 had Velcro wraps applied daily, on in the mornings and off at bedtime. The DON confirmed that R2's TAR indicated no edema was present the prior day or that morning and stated she guessed it was not being specifically monitored other than when the Velcro wraps were applied. The DON noted staff were not monitoring R2's edema every shift or at least were not doing good documentation of doing so and R2's physician order directed staff to monitor the edema every shift. The DON stated she would expect edema to be on a resident's care plan, it should be captured in the skin section, and R2 had a skin care plan but it did not include edema. In the same interview on 4/29/24 at 11:08 a.m., the DON noted the facility had a dietician who monitored and audited resident weights weekly. The DON stated a significant weight change would probably be about a five lb. increase in one week. The DON identified that dietary updated hospice about R2's weight gain on 3/12/24 regarding his weight of 175.4 lbs. on 3/7/24. The DON confirmed that R2's weight on 4/25/24 was 181.4 lbs., which was an increase of 16 pounds since admission and 6 lbs. since 3/7/24. The DON stated she would expect hospice to be notified of the continued weight gain and there was no charting indicating hospice had been updated since 3/12/24. In the same interview on 4/29/24 at 11:08 a.m., the DON stated comprehensive assessments of wounds included the skin evaluation and would identify the site of the wound, if there was	F 684		

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F 684	Continued From page 15 drainage, the type of wound, if someone had medications or diagnoses with the potential to delay healing or increase risk of compromised skin integrity, and what follow-up or treatments were. The DON stated she would want a description of the wound and what it is and the size of the wound and the facility always captured the size of a wound for the purpose of tracking healing. The DON confirmed that documentation of skin tears in R2's EHR included descriptions such as them being superficial and some included a description of small or large but they did not include length or width measurements and specifics of the exact sizes of the wounds were missing. Facility policy titled Resident Weight Evaluation dated 9/2012, included: "Policy Statement: ... To ensure that resident weight gains and losses are assessed regularly based on a comprehensive resident assessment and that follow-up interventions are implemented to ensure the resident reaches their highest potential ... Policy Interpretation and Implementation: ... 3.) When a weight is completed, it is documented on the Electronic Record by the nurse. The record will have a history of at least two months of past weights on it. Should the nurse note a five pound weight increase or decrease, he/she must weigh that individual again; 4.) If there is a weight change that meets the above criteria, the charge nurse and Hospitality Services Director determine the appropriate intervention and make a referral to the Dietitian. The Dietitian initiates a preliminary assessment to determine the cause and charts this in the nurses' notes. (Appropriate interventions might be requesting a diet change, encouraging low or high calorie snacks, Kemps	F 684		

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F 684	Continued From page 16 Plus, milkshakes, lab work, weekly weights, double desserts, etc.); 5.) At the discretion of the charge nurse and dietician, the Physician is notified." Facility policy titled Skin Assessment & Wound Management dated 3/2024, included: "When a significant alteration in skin integrity is noted (i.e. large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken ... 10.) Initiate Skin and Wound Evaluation; 11.) Notify Nurse Manager/Wound Nurse; 12.) Referral to dietary, if appropriate; 13.) Referral to therapies, if appropriate; 14.) Review and update care plan including interventions; 15.) Update resident care lists; 16.) Updated care plan to identify risks for skin breakdown. A facility policy regarding management of edema was requested but not provided.	F 684		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/25/24 and 4/29/24, 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 order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaint was reviewed: H52763391C (MN00102743) with a licensing order issued at 0830. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor edema and comprehensively assess non-pressure related wounds for 1 of 1 resident (R2) reviewed. Findings Include: R2's admission Minimum Data Set (MDS) dated 2/25/24, indicated R2 was admitted on 2/19/24 with diagnoses including malignant neoplasm of brain (brain cancer), hypertension, and chronic	2 830	Corrected	5/23/24

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2 830	Continued From page 3 ischemic heart disease (weakening of the heart caused by reduced blood flow) and was receiving hospice care. R2's active physician order dated 2/19/24, directed nurses to chart R2's condition in nurse's notes every shift for edema (fluid retention in body tissues that can result in swelling and/or weight gain) checks noting edema as present or not present and lung checks noting lungs as clear or not clear. R2's treatment administration records (TAR) were reviewed in conjunction with progress notes and skin evaluations, it was not evident edema was consistently comprehensively evaluated. Although the TAR's which identified the physician orders for edema checks and lung sounds were completed, the extent of edema was not included. Instead the TAR for edema monitoring documentation had plus signs (+) indicating edema was present or minus signs (-) indicating no edema. In the boxes for lung sounds the boxes identified (cl) for clear and (+) for not clear. R2's active physician order dated 2/19/24, directed staff to complete weekly weights for R2 every Thursday. R2's weight record was reviewed in conjunction with progress notes and skin evaluations, R2's weight record identified between 2/19/24 to 4/25/24, R2 had a weight gain of 16.2 pounds (lbs). It was not evident R2's weight gains were comprehensively assessed to ascertain if the gains were nutritional and/or fluid related in order to evaluate for a change in R2's overall health status and possible disease progression and further treatment needs.	2 830		

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2 830	Continued From page 4 Weights documented in R2's electronic health record (EHR) included: 181.4 pounds (lbs.) on 4/25/24 at 2:34 p.m. 181.4 lbs. on 4/25/24 at 12:48 p.m. 177.2 lbs. on 4/18/24 at 1:58 p.m. 177.2 lbs. on 4/18/24 at 1:55 p.m. 177.2 lbs. on 4/18/24 at 1:52 p.m. 180.8 lbs. on 4/11/24 at 2:47 p.m. 180.8 lbs. on 4/11/24 at 1:59 p.m. 181.0 lbs. on 4/4/24 at 2:56 p.m. 181.0 lbs. on 4/4/24 at 12:28 p.m. 182.4 lbs. on 3/28/24 at 12:18 p.m. 182.4 lbs. on 3/28/24 at 10:13 p.m. 177.4 lbs. on 3/21/24 at 1:44 p.m. 177.4 lbs. on 3/21/24 at 12:40 p.m. 176.6 lbs. on 3/14/24 at 8:59 p.m. 176.6 lbs. on 3/14/24 at 2:00 p.m. 176.6 lbs. 3/14/24 at 9:33 a.m. 175.4 lbs. on 3/7/24 at 1:59 p.m. 175.4 lbs. on 3/7/24 at 1:36 p.m. 171.4 lbs. on 2/29/24 at 2:49 p.m. 171.4 lbs. on 2/29/24 at 1:30 p.m. 169.6 lbs. on 2/22/24 at 10:42 a.m. 169.6 lbs. on 2/22/24 at 10:21 a.m. 165.2 lbs. on 2/19/24 at 2:20 p.m. 165.2 lbs. on 2/19/24 at 12:49 p.m. 165.2 lbs. on 2/19/24 at 12:32 p.m. A provider note dated 2/21/24, from R2's initial encounter indicated "due to progressive functional and cognitive decline, oncology recommended transition to hospice. He is admitted here for LTC [long term care] on [agency name] hospice." It also noted R2 reported he quite smoking 39 years ago and his smoking use included cigarettes. R2's Weekly Skin Inspection dated 2/22/24, noted R2 had large bruises on his left inner and outer elbow and a scar, bruising on bilateral lower	2 830		

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2 830	Continued From page 5 extremities (BLE, both legs), a scar on the left shin, and scratches on knees and shin. It did not note any other skin concerns or edema. R2's Skin Evaluation and Skin Risk Factors assessment dated 2/23/24, noted R2 had a left antecubital (inner elbow) skin tear, bruising on the left elbow, scar on the left elbow, and identified a skin issue on the left forearm but did not specify what type of issue. The description and summary sections noted R2 had a large superficial skin tear on his left forearm and an unspecified wound bed looked red. Drainage was listed as N/A, the periwound description and measurements were not completed. Risk factors selected from a pre-populated list of options were psychotropic drug use. R2's hypertension, cancer, history of smoking, left side hemiparesis, and cognitive impairment were not identified. The summary indicated R2 had no feeling on the left side as he said his left side upper and lower extremities are numb. No interventions were listed in the interventions section. R2's Wound Evaluation Form dated 2/23/24, noted a left forearm skin tear that was superficial with a red wound bed. A dressing was applied to the wound bed and covered with a gauze, no pain was associated with wound care. The measurements section was not completed. No additional Wound Evaluation Forms were identified during review of R2's EHR. A hospice communication note date 2/26/24, indicated wound care was completed for the left arm and included the following measurements of unspecified wounds: 4 x 2.5 centimeters (cm), 2.5 x 2 cm, 1 x 1 cm, 1 x 0.5 cm, and 1 x 0.5 cm. Information about the specific wound locations, types, wound beds, drainage, odor, periwound	2 830		

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2 830	Continued From page 6 area and wound edges, risk factors, and pain was not documented. R2's Weekly Skin Inspection dated 2/29/24, bruising on the left elbow, arm, and back of left hand, some scars and skin tears, bruising and scars on the back of the right hand, bruising on BLE, and signs of edema on both feet. Information about the specific wound locations, wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. Assessment of the edema was also not documented. A hospice communication note dated 3/1/24, indicated wound cares were completed on the left arm and included measurements of 4.5 x 1.5 cm outer left forearm wound, 2 x 1.5 cm inner left forearm wound, 1 x 1 cm elbow wound, and 1 x 1 and 0.5 x 0.5 cm wounds on the bottom of the left arm. Information about the wound types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A hospice communication note dated 3/5/24, indicated wound care was performed and included wound measurements of 3 x 2 cm, 0.5 x 1 cm, and 1 x 1 cm on the left top arm and 2 x 2 cm, 0.5 x 0.5 cm, and 1 x 1 cm on the left bottom arm. Information about the specific wound locations, wound types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's active physician order dated 3/7/24, directed staff to apply Velcro wraps (compression wraps) to BLE. R2's Weekly Skin Inspection dated 3/7/24, noted	2 830		

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2 830	Continued From page 7 R3 had bruising on "BLU" (possible mis-type of BUE, bilateral upper extremities) and BLE with scars. It did not identify any edema or further skin issues. A hospice communication note dated 3/8/24, indicated wound care was performed. No information about the wounds was documented. A hospice communication note dated 3/11/24, indicated wound cares were completed on the left arm, four of five wounds were resolved, and included a measurement of 0.8 x 1 cm of a wound on [illegible] left forearm. Information about the wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 3/12/24, noted a 30-day nutritional review was completed by dietary and identified a weight of 175.4 lbs. on 3/7/24, weight gain noted since admission, family and hospice updated, registered dietician will continue to observe per facility protocol. A progress note dated 3/12/24, noted R2 said he was going through a door and squeezed his left arm against the door, sustaining a skin tear on the left elbow. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's care plan identified a risk for alteration in skin integrity related to frail skin, left-sided hemiparesis (one-sided muscle weakness), and weakness dated 3/13/24. Interventions included application of a geri-sleeve (sleeve to protect fragile skin) to left and right arms covering R2's hands, forearms, and elbows to prevent skin	2 830		

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2 830	Continued From page 8 tears/abrasions, inspection of skin daily with nursing aides to report any concerns to nurse, and weekly skin assessment by licensed staff. R2's skin care plan did not identify his edema or included related interventions. R2's Skin Evaluation and Skin Risk Factors assessment dated 3/13/24, identified a left elbow skin tear. The wound bed was described as approximated edges with steri-strips (adhesive bandages) applied. It noted the periwound area (skin surrounding the wound) was intact and the wound bled a small amount at first with no further drainage. The presence of a new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were cognitive impairment and other: left side hemiparesis. R2's psychotropic drug use, hypertension, cancer, and history of smoking were not identified. Interventions included R2 wearing a geri-sleeve on the left arm. The summary described the incident causing the skin tear. R2's Weekly Skin Inspection dated 3/14/24, noted bruising on bilateral upper extremities (BUE) with wounds in healing on the left arm and scars as well as bruising on BLE. Information about the number and location of the wounds on the left arm, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema. A progress note dated 3/15/24, noted a new small skin tear with a scab forming on the left forearm was identified while resident's geri-sleeve was removed for a shower. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk	2 830		

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2 830	Continued From page 9 factors, and pain was not documented. A hospice communication note dated 3/15/24, indicated wound care was completed for the left arm. Information about the number and location of the wound(s) on the left arm, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's Skin Evaluation and Skin Risk Factors assessment dated 3/15/24, noted skin tears on the left elbow and left forearm. The wound bed noted steri-strips on the left elbow skin tear and a small skin tear on the left forearm with a scab forming and Band-Aid applied. Drainage description noted scant blood but did not identify the associated wound(s). The periwound area was described as intact with no open areas. The presence of a new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were cognitive impairment, psychotropic drug use, and other: left side hemiparesis. R2's hypertension, cancer, and history of smoking were not identified. Interventions included geri-sleeve on left arm, wheelchair cushion, and an extended wheelchair arm rest for the left side requested from hospice. Information about the wound measurements and pain was not documented. A hospice communication note dated 3/19/24, indicated wound care was completed for the left leg and left arm. It noted "left leg is new, unsure cause but appears vascular due to edema." Information about the extent of the edema was not identified. Furhter the number and location of the wounds, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not	2 830		

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2 830	Continued From page 10 documented. R2's Weekly Skin Inspection dated 3/21/24, noted bruising on BUE with scars on the back of both hands and open wounds on the left elbow, bruising on BLE, scars and a wound on the left shin, and bruising on the left side of the neck. Information about the number and location of the wound(s) on the left elbow, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema. A hospice communication note dated 3/21/24, indicated wound care was completed, there was no complaint of pain, no signs or symptoms of infection, and included the following measurements: 1.5 x 1 cm left lateral arm wound, 3 x 2 cm left arm wound, and 1 x 0.5 cm left leg wound. Information about the wound beds, drainage, odor, periwound area and wound edges, and risk factors was not documented. A progress note dated 3/22/24, noted assessment was done of the right leg due to the weekly skin check indicating the presence of a wound. No wound or open area was noted, a small intact scab was identified. A hospice communication note dated 3/25/24, indicated wound care was completed on the left leg and arm. It noted "several new wound[s] to left arm, will reassess on next visit for measurements." Information about the specific location of the wounds, measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.	2 830		

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2 830	Continued From page 11 R2's active physician order dated 3/25/24, directed that R2 take 4 milligrams (mg) of dexamethasone (a steroid medication) by mouth once daily. R2's Weekly Skin Inspection dated 3/28/24, noted bruising on BUE with scars, an open area on the left forearm, bruising on the right lower extremity, and small scab on the right lower shin. Information about the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema. R2's Fall from Chair report dated 3/28/24, noted R2 fell and sustained injuries including bleeding from the left elbow at the site of a previous injury, and a skin tear in the inner upper arm. The left elbow injury was identified as a skin tear. Information about the measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 3/31/24, noted R2 was found on the floor and sustained skin tears on the right arm and left hand. Information about the specific of the right arm wound, wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 3/31/24, noted the on-call provider ordered monitoring of R2's skin tears. R2's Weekly Skin Inspection dated 4/4/24, noted bruising and scars on BUE, right lower extremity bruising, and a scab on the right shin. It did not identify edema.	2 830		

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2 830	Continued From page 12 R2's Weekly Skin Inspection dated 4/11/24, noted bruising and scars on BUE, multiple bruises on the left arm, bruising on the right lower extremity, and a superficial scratch on the right thigh. It did not identify edema. A progress note dated 4/12/24, noted R2 bumped his hand on the toilet grab bar when sitting down and sustained a skin tear on the right hand. Information about the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. R2's Skin Evaluation and Skin Risk Factors assessment dated 4/12/24, noted a skin tear on the back of the right hand. The description noted it was superficial with a wound bed of 100% epithelial tissue, drainage was a small amount of bleeding, and the periwound area had peeled skin around the edges of the wound. A new wound prompting assessment was marked yes. Risk factors identified included other: hemiplegia and frail skin. R's psychotropic drug use, steroid medication, hypertension, cancer, history of smoking, and cognitive impairment were not identified. No interventions were identified. R2's Weekly Skin Inspection dated 4/18/24, noted bruising and scars on BUE, a scar on the right thigh, and some small bruising on the right lower extremity. It did not identify edema and noted there were no other skin issues at the time. A Fall Review Evaluation dated 4/20/24, noted R2 fell in the bathroom and no injury was found. A progress note dated 4/22/24, noted the inter-disciplinary team reviewed R2's fall on 4/20/24 and R2 had a small, scabbed area on his	2 830		

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2 830	Continued From page 13 right posterior arm related to the fall. It did not include further assessment of the newly identified scabbed area. A progress noted dated 4/22/24, noted R2 had a skin tear on his right arm close to the elbow and the nurse manager was notified. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. A progress note dated 4/24/24, noted R2 obtained a skin tear on 4/24/24 and had fragile skin and was at high risk for skin tears. Information about the specific wound location, wound measurements, wound bed, drainage, odor, periwound area and wound edges, specific risk factors, and pain was not documented. R2's Skin Evaluation and Skin Risk Factors assessment dated 4/24/24, listed left elbow skin tear injury. The wound beds were described as superficial with a red periwound area. The summary noted R2 had two open area on his left elbow that looked superficial. The drainage section was not complete. A new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were psychotropic drug use. R2's steroid medication, cognitive impairment, hemiparesis, hypertension, cancer, and history of smoking were not identified. No interventions were identified. Information about wound drainage, odor, pain, and measurements was not documented. R2's Weekly Skin Inspection dated 4/25/24, noted wounds on the left elbow and bruising, bruising and a wound on the right forearm, and bruising	2 830		

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2 830	Continued From page 14 on the left lower extremity. Information about the specific number and location of the left elbow wounds, measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. No edema was identified. A hospice communication note dated 4/25/24, indicated wound care was completed on the "Lt. FA [left forearm?]," there was stinging afterwards, and R2 took a dose of as needed Tylenol. Information about the number of wounds, wound measurements, wound beds, drainage, odor, periwound area and wound edges, and risk factors was not documented. R2's Treatment Administration Record (TAR) included the active physician order for edema checks. Charting from the day shift on 4/29/24 noted no edema was present. During an observation on 4/29/24 at 10:22 a.m., R2's feet were examined with registered nurse (RN)-A. RN-A stated R2's right foot was swollen with pitting edema measuring 2+ to 3+ (edema that leaves a dimple after being pressed is pitting and is measured by depth of indention from 1+ most shallow to 4+ deepest) that extended up to his ankle. RN-A stated R2's left foot had pitting edema of 1+ on the inner side and 2+ on the left side extending up to his ankle. RN-A stated R2 had a history of edema and staff put socks and Velcro wraps on him every day and checked his feet and edema at this time. RN-A indicated that she would complete a progress note if edema was noted or, on shower days, a skin check was completed and she would include the edema in that documentation. RN-A stated if a nurse saw edema they would document it and include if it was trace edema, pitting edema, and the grade.	2 830		

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2 830	Continued From page 15 During an interview on 4/29/24 at 10:26 a.m., R2 stated he wore the Velcro sleeves on his legs to help with the swelling and before he wore them his skin was swelling up so much it was breaking open. R2 stated the swelling was present for at least the last six months in both of his feet and he wore the Velcro sleeves every day. In an interview on 4/29/24 at 11:08 a.m., the director of nursing (DON) stated edema is monitored through daily observation from the aides who would notify the nurse of any concerns. The DON stated nurses also observe residents when they give medications and complete weekly skin checks. The DON noted the weekly skin checks should say if edema was noted and if it was pitting and the grade. The DON stated that if it was not the day of the week for the weekly skin check then edema would be documented in a progress note. The DON stated R2 had Velcro wraps applied daily, on in the mornings and off at bedtime. The DON confirmed that R2's TAR indicated no edema was present the prior day or that morning and stated she guessed it was not being specifically monitored other than when the Velcro wraps were applied. The DON noted staff were not monitoring R2's edema every shift or at least were not doing good documentation of doing so and R2's physician order directed staff to monitor the edema every shift. The DON stated she would expect edema to be on a resident's care plan, it should be captured in the skin section, and R2 had a skin care plan but it did not include edema. In the same interview on 4/29/24 at 11:08 a.m., the DON noted the facility had a dietician who monitored and audited resident weights weekly. The DON stated a significant weight change	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00520	A. BUILDING: _____ B. WING _____	C 04/29/2024

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2 830	Continued From page 16 would probably be about a five lb. increase in one week. The DON identified that dietary updated hospice about R2's weight gain on 3/12/24 regarding his weight of 175.4 lbs. on 3/7/24. The DON confirmed that R2's weight on 4/25/24 was 181.4 lbs., which was an increase of 16 pounds since admission and 6 lbs. since 3/7/24. The DON stated she would expect hospice to be notified of the continued weight gain and there was no charting indicating hospice had been updated since 3/12/24. In the same interview on 4/29/24 at 11:08 a.m., the DON stated comprehensive assessments of wounds included the skin evaluation and would identify the site of the wound, if there was drainage, the type of wound, if someone had medications or diagnoses with the potential to delay healing or increase risk of compromised skin integrity, and what follow-up or treatments were. The DON stated she would want a description of the wound and what it is and the size of the wound and the facility always captured the size of a wound for the purpose of tracking healing. The DON confirmed that documentation of skin tears in R2's EHR included descriptions such as them being superficial and some included a description of small or large but they did not include length or width measurements and specifics of the exact sizes of the wounds were missing. Facility policy titled Resident Weight Evaluation dated 9/2012, included: "Policy Statement: ... To ensure that resident weight gains and losses are assessed regularly based on a comprehensive resident assessment and that follow-up interventions are implemented to ensure the resident reaches their highest potential ... Policy Interpretation and Implementation: ... 3.) When a	2 830		

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2 830	Continued From page 17 weight is completed, it is documented on the Electronic Record by the nurse. The record will have a history of at least two months of past weights on it. Should the nurse note a five pound weight increase or decrease, he/she must weigh that individual again; 4.) If there is a weight change that meets the above criteria, the charge nurse and Hospitality Services Director determine the appropriate intervention and make a referral to the Dietitian. The Dietitian initiates a preliminary assessment to determine the cause and charts this in the nurses' notes. (Appropriate interventions might be requesting a diet change, encouraging low or high calorie snacks, Kemps Plus, milkshakes, lab work, weekly weights, double desserts, etc.); 5.) At the discretion of the charge nurse and dietician, the Physician is notified." Facility policy titled Skin Assessment & Wound Management dated 3/2024, included: "When a significant alteration in skin integrity is noted (i.e. large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken ... 10.) Initiate Skin and Wound Evaluation; 11.) Notify Nurse Manager/Wound Nurse; 12.) Referral to dietary, if appropriate; 13.) Referral to therapies, if appropriate; 14.) Review and update care plan including interventions; 15.) Update resident care lists; 16.) Updated care plan to identify risks for skin breakdown. A facility policy regarding management of edema was requested but not provided.	2 830		

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2 830	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review all residents with edema to ensure they are receiving ongoing monitoring and assessment of the edema as well as revise skin care related policies to include standards of care for edema. The director of nursing or designee could conduct random audits of nursing assessments to ensure appropriate care and services are implemented and reduce the risk of edema not being monitored properly. The director of nursing of designee could review all residents with non-pressure related wounds to ensure they are being comprehensively assessed. The director of nursing or designee could re-educate nursing staff about wound assessment policies and conduct random audits of non-pressure related wound assessments to ensure wounds are assessed appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		