DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2025

Administrator
The Emeralds at St. Paul

420 MARSHALL AVENUE
SAINT PAUL, MN 55102

RE: CCN: 245295
Cycle Start Date: April 23, 2025

Dear Administrator:

On May 20, 2025, we notified you a remedy was imposed. On June 5, 2025 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 May 22, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 4, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 20, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 5, 2025. 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 14, 2025

Administrator
The Emeralds at St. Paul
420 Marshall Ave
Saint Paul, MN 55102

Re: Reinspection Results
Event ID: H42812 and HY5G12

Dear Administrator:

On June 2, 2025 and June 6, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on April 23, 2025 and May 5, 2025. 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
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Electronically delivered

May 20, 2025

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: April 23, 2025

Dear Administrator:

On May 14, 2025, we informed you that we may impose enforcement remedies.

On May 5, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On May 2, 2025, the situation of immediate jeopardy to potential health and safety cited at F686 was removed. However, continued non-compliance remains at the lower scope and severity of D.

On May 2, 2025, the situation of immediate jeopardy to potential health and safety cited at F697 was removed. However, continued non-compliance remains at the lower scope and severity of D.

On May 2, 2025, the situation of immediate jeopardy to potential health and safety cited at F849 was removed. However, continued non-compliance remains at the lower scope and severity of D.

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 June 4, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 4, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 4, 2025.

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

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, The Emeralds At St Paul Llc is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 5, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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, Rapid Response
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 October 23, 2025 (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:

tamika.brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies

through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

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 20, 2025

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: H5YG11

Dear Administrator:

The above facility was surveyed on April 28, 2025 through May 5, 2025 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, Rapid Response
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
	245295	A. BUILDING _____ B. WING _____	C 05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

(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 4/28/25 - 5/5/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52953591C (MN1112561) with a deficiency issued at F641, F686, F697, and F849. Deficient practice was identified related to incidental finding at F700 and F909. The survey resulted in an Immediate Jeopardy (IJ) at F686, F697, and F849. F686 Based on observation, interview, and document review, the facility failed to complete a comprehensive skin assessment identifying pressure ulcers, treatments, and monitoring, resulting in serious harm, for 1 of 3 residents (R1) reviewed for pressure ulcers. R1 returned from a hospital admission and the hospital discharge summary indicated upon admission to the hospital, R1 had pressure ulcers to his coccyx, left heel, right heel, lateral right foot. The treatment for all the wounds was to cleanse and change the dressing. This resulted in an Immediate Jeopardy for R1 when the facility failed to provide the necessary treatment to R1 upon his return from the hospital for approximately six weeks. The immediate jeopardy began on 3/19/25 and the immediacy was removed on 5/2/25.	F 000		

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

Electronically Signed | 05/22/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See 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 000	Continued From page 1	F 000		

F697
Based on observation, interview, and record review the facility did not ensure a residents pain was managed in accordance with professional standards of practice and hospice plan care, for 1 of 3 residents (R1) reviewed for pain. R1's medication regimen was ineffective; he would scream and moan in pain contacting EMS and his daughter for help. This resulted in immediate jeopardy (IJ) when the facility did not have a system in place to manage R1's pain causing R1 unnecessary physical and psychological harm.

The immediate jeopardy began on 4/1/25 and the immediacy was removed on 5/2/25.

F849
Based on observation, interview and document review, the facility failed to establish a communication process between the facility and the hospice provider to ensure that the needs of a resident were addressed and met for 1 of 3 residents (R1) reviewed for hospice services. This resulted in an immediate jeopardy (IJ) when R1 did not receive the necessary care and services for the treatment of pressure ulcers and pain management. R1's pressure ulcer went untreated for approximately six weeks and R1's pain was not controlled, limiting staff's ability to perform activities of daily living for R1. In addition, the facility failed to have a designated member of the interdisciplinary team who was responsible to work with hospice to ensure residents receiving hospice services needs were met.

The immediate jeopardy began on 3/19/25 and the immediacy was removed on 5/2/25.

The above findings constituted substandard

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THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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F 000	Continued From page 2 quality of care, and an extended survey was conducted from 5/2/25 to 5/5/25. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 641		5/28/25

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F 641	Continued From page 3 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident assessment accurately reflected a resident health status for 1 of 3 residents (R1) reviewed when R1's significant change of status did not reflect R1's pressure ulcers. Findings include: R1's quarterly Minimum Data Set dated 2/6/25 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 14 indicting R1 was cognitively intact. R1's hospital discharge summary dated 3/18/25, received by the facility 3/19/25 indicated R1 was discharged with hospice services. R1 had the following wounds: -Wound first assessed on 3/17/25 on his coccyx (tailbone) the wound was identified as moist and blanchable (skin discoloration that disappears pressed upon and return when pressure is released indicating the blood vessels in the areas are occluded therefore blood flow is obstructed), the peri wound (area surrounding the wound) was excoriated, red and moist. Mepilex dressing was used to cover the wound following cleansing. -Suspected pressure ulcer to R1's left heel first assessed 3/17/25 the wound was purple, red, and	F 641	R1 passed away on 05/01/2025. R1's 03/26/2025 Significant Change MDS was modified to include wounds that were present upon readmission from hospital. Facility reviewed like-residents to ensure their assessments were accurate and captured in their most recent MDS. All residents have the potential to be affected by this deficient practice. Staff provided education related to comprehensive assessments and ensuring it accurately reflects the resident's status at the time of assessment. The DON or designee will conduct related to comprehensive assessments and ensuring it accurately reflects the resident's status at the time of assessment weekly times 4 weeks. Audit results will be brought to QAPI for further review and recommendation.	

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F 641	Continued From page 4	F 641		

fragile, the peri wound area was intact and red. The wound was cleansed and a Mepilex dressing applied.
-Suspected pressure ulcer to R1's right heel first assessed 3/17/25 the wound was red and intact, cleansed and covered with a Mepilex dressing.
-Suspected pressure ulcer to the left anterior foot first assessed 3/17/25 the wound was fragile, red, and intact, cleansed and covered with a Mepilex dressing.
-Wound to the right lateral foot first assessed 3/18/25 the wound was fragile, red, pink with black eschar (scabbing) painful, cleansed and covered with Mepilex.
-Wound to the right anterior knee first assessed 3/17/25 the wound was fragile and tan, cleansed and covered with a dressing.

R1's hospice plan of care dated 3/19/25 indicated R1's terminal diagnosis was acute hypoxic respiratory failure. Wound care order: Sacral wound and bilateral lower extremity wounds: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound skin. Cover with a foam bandage three times a week and as needed. Wound care was to be performed by the facility staff. R1's pain was to be managed and reported if not controlled at 0-3 of 10 pain scale.

R1's significant change Minimum Data Set (MDS) dated 3/26/25 did not indicate a Brief Interview for Mental Status (BIMS) score, R1 was dependent on staff assistance with toileting, showering, dressing, personal hygiene, rolling in bed, bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were chronic congestive heart failure, opioid dependent, pain and chronic obstructive pulmonary disease. The MDS indicated there

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THE EMERALDS AT ST PAUL LLC	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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F 641	Continued From page 5 were no pressure ulcers or any other skin conditions or wounds to the feet. Upon observation and interview on 4/28/25 at 3:39 p.m. R1 was on his back in a hospital bed wearing a hospital gown telling a friend about his back pain. R1 agreed to a skin inspection, but stated he was in so much pain it caused severe pain to move him. He requested the assistance of three staff members and requested they move him slowly. R1 had dried blood on all five toes of his right foot. The second toe of his right foot had a dirty bandage on it. R1's sheet was pulled back and pressure ulcers were observed on both heels, and a pressure ulcer on his right lateral foot. Staff attempted to roll R1 onto his left side. R1 screamed in pain and gripped the side rail. He was screaming for staff to stop. He was laid back on this back. R1's coccyx area appeared red, it was difficult to visualize and make an assessment as R1's pain level was so great the staff had to reposition him back on his back within seconds. At 3:58 LPN-B gave R1 a pain medication. At 5:00 p.m. R1 continued to state his pain was a 10/10 and staff was still unable to move him. R1 was not offered any addition management for his pain. The director of nursing (DON) was notified, and the staff began to assess R1's skin. R1's skin and wound evaluation on 4/28/25 at 4:51 p.m. indicated R1 had a pressure ulcer (deep tissue injury) on his right medial malleolus (inside of the ankle) in-house acquired with an area 1.5 centimeters squared (cm), length 1.9 cm, width 1.1 cm. There was no documentation of the wound bed. R1's Skin and wound evaluation on 4/28/25 at	F 641		

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F 641	Continued From page 6 4:56 p.m. indicated R1 had an unstageable (obscured full-skin and thickness skin and tissue loss) pressure ulcer on his right lateral (outside) foot in-house acquired. The wound area measured 4.3 cm, length 3.1 cm, width 1.8 cm, 0 depth, 60 % granulated (healing tissue in a wound bed), 40% slough (dead tissue and debris in a wound bed), light exudate (fluid in the wound, part of the healing process). R1's skin and wound evaluation on 4/29/25 at 7:24 a.m. indicated R1 had unstageable pressure ulcer on his sacrum in-house acquired with an area of 32.9 cm, length 5.4 cm and with 7.8 cm, 0 depth. The wound was 50% granulated and 20% slough and 30% eschar (scab, dead cells). The wound had moderate serosanguineous exudate (mixture a watery bodily fluid and blood). R1's weekly skin inspection summary dated 4/29/25 at 7:57 a.m. indicated R1 had a pressure on his sacrum, left and right buttocks. Pressure wound on his right lateral malleolus. Pressure wound on his right lateral foot. Pressure wound on his right medial malleolus. Abrasion of his left dorsum (top) 5th toe. Abrasion of his right dorsum 2nd toe. Abrasion of his right dorsum 1st toe. The wounds were assessed by the in-house wound nurse and treatment completed. Hospice and medical provider updated, and treatment orders obtained. Upon interview on 4/30/25 at 9:15 a.m. the MDS nurse, RN-G stated when she assesses a patient, she reads the hospital discharge and progress notes. Upon R1's hospital record review she identified the resident did have wounds leaving the hospital and stated she missed the wounds because there were no hospital orders for	F 641		

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F 641	Continued From page 7 wounds. RN-G stated she does not observe the residents skin herself, or assess pain, she receives her information by what the facility nurses chart on their assessments. In addition, she did not interview the resident regarding his skin condition. Upon interview on 4/30/25 at 9:46 a.m. the director of nursing, (DON) stated the nurse who completed R1's assessment did miss the wounds, however the wounds were the responsibility of hospice, so the facility would not "necessarily" have documented the wounds. Upon interview and record review on 4/30/25 at 11:30 a.m. the Administrator stated she would expect the facility to note and assess all wounds on their residents and add to the care plan. If during a facility assessment a wound was covered, she would expect the staff to remove the dressing if it were removable and assess the wound. A facility policy titled Care planning indicated the development of a baseline care plan and a comprehensive care plan it did not indicate the development of a significant change care plan.	F 641		
F 686 SS=J	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	F 686		5/5/25

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F 686	Continued From page 8 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 observation, interview, and document review, the facility failed to complete a comprehensive skin assessment identifying pressure ulcers, treatments, and monitoring, resulting in serious harm, for 1 of 3 residents (R1) reviewed for pressure ulcers. R1 returned from a hospital admission and the hospital discharge summary indicated upon admission to the hospital, R1 had pressure ulcers to his coccyx, left heel, right heel, lateral right foot. The treatment for all the wounds was to cleanse and change the dressing. This resulted in an Immediate Jeopardy for R1 when the facility failed to provide the necessary treatment to R1 upon his return from the hospital for approximately six weeks. The immediate jeopardy began on 3/19/25, when R1 returned from a hospital admission with pressure ulcers. These pressure ulcers were not treated for approximately six weeks. The administrator, director of nursing, and regional nurse manager were notified of the immediate jeopardy at 5:10 p.m. on 5/1/25. The immediate jeopardy was removed on 5/2/25, but noncompliance remained at the lower scope and severity level 2 D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 686	R1 passed away on 05/01/2025. R1's 03/26/2025 Significant Change MDS was modified to include wounds that were present upon readmission from hospital. Residents who were identified at very high and high risk for pressure ulcers have had a comprehensive skin assessment to ensure no skin breakdown or wounds were identified. All residents have the potential to be affected by this deficient practice. Nursing staff were educated on the Monarch Wound and Skin Policy, including the completion of comprehensive skin assessments, obtaining wound orders when new wounds are identified, notification of provider, and updating resident care plans. The DON or designee to audit 5 residents weekly times for weeks, then monthly times 2 months resident s who trigger very high and high risk for skin breakdown and ensure that skin assessment was completed and any new or worsening skin breakdown was communicated to the provider, treatment orders in place, and	

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F 686	Continued From page 9 Findings include: Upon observation and interview on 4/28/25 at 3:39 p.m. R1 was on his back in a hospital bed wearing a hospital gown telling a friend about his back pain. R1 agreed to a skin inspection, but stated he was in so much pain it caused severe pain to move him. He requested the assistance of three staff members and requested they move him slowly. R1 had dried blood on all five toes of his right foot. The second toe of his right foot had a dirty bandage on it. R1's sheet was pulled back and pressure ulcers were observed on both heels, and a pressure ulcer on his right lateral foot. Staff attempted to roll R1 onto his left side. R1 screamed in pain and gripped the side rail. He was screaming for staff to stop. He was laid back on this back. R1's coccyx area appeared red, it was difficult to visualize and make an assessment as R1's pain level was so great the staff had to reposition him back on his back within seconds. At 3:58 LPN-B gave R1 a pain medication. At 5:00 p.m. R1 continued to state his pain was a 10/10 and staff was still unable to move him. R1 was not offered any addition management for his pain. The director of nursing (DON) was notified, and the staff began to assess R1's skin. According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, indicated: -"Pressure Ulcer/Injury (PU/PI)" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the	F 686	care plan updated to reflect changes. Audit results to be reviewed at QAPI for further recommendations.	

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F 686	Continued From page 10 appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. - "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. -Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). -Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin	F 686		

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F 686	Continued From page 11 folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). R1's physician orders dated 2/24/25 - 4/27/25 indicated on 2/25/25 R1 was to have the skin around his nose and behind his ears checked due to any skin concerns due to his oxygen tubing. On 3/4/25 R1 was to have weekly skin inspections by nursing staff. On 4/8/25 R1 had wound care to cleanse wound to right ankle with wound cleanser, pat dry and apply foam gauze dressing daily and as needed. No other wound orders were documented. R1's nursing progress note dated 3/4/25 indicated the wound practitioner saw R1 on wound rounds for an abscess on buttocks. The abscess was improving. The abscess was located on the right gluteal fold (area where the leg meets the buttocks). R1's nursing progress note dated 3/7/25 the interdisciplinary team (IDT) team met and reviewed the weekly wound rounds. R1's orders were up to date for the abscess to his right gluteus. R1's nursing progress note dated 3/14/25 a chest x-ray was ordered. R1 was alert and oriented. Vital signs within normal limits. Administered all medications to and wound care completed to coccyx/buttocks, no signs of infection. There were no measurements, assessment, or what type of treatment were completed to coccyx. The note failed to identify if this was a new area and/or if physician had been notified. R1's nursing progress notes dated 3/15/25 identified R1 was transferred to the hospital due	F 686		

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F 686	Continued From page 12 to acute confusion, jitteriness, and a blood pressure of 70/40 (normal 120/80). R1 had ongoing wounds on his buttocks. The note failed to identify what types of wounds, any measurement or description. R1's hospital discharge summary dated 3/18/25 received by the facility on 3/19/25 indicated: -Wound first assessed on 3/17/25 on his coccyx (tailbone) the wound was identified as moist blanchable (skin discoloration that disappears pressed upon and return when pressure is released indicating the blood vessels in the areas are occluded therefore blood flow is obstructed), the peri wound (area surrounding the wound) was excoriated, red and moist. Mepilex dressing was used to cover the wound following cleansing. -Suspected pressure ulcer to R1's left heel first assessed 3/17/25 the wound was purple, red, and fragile, the peri wound area was intact and red. The wound was cleansed and a Mepilex dressing applied. -Suspected pressure ulcer to R1's right heel first assessed 3/17/25 the wound was red and intact, cleansed and covered with a Mepilex dressing. -Suspected pressure ulcer to the left anterior foot first assessed 3/17/25 the wound was fragile, red, and intact, cleansed and covered with a Mepilex dressing. -Wound to the right lateral foot first assessed 3/18/25 the wound was fragile, red, pink with black eschar (scabbing) painful, cleansed and covered with Mepilex. -Wound to the right anterior knee first assessed 3/17/25 the wound was fragile and tan, cleansed and covered with a dressing. R1's hospital discharge summary dated 3/18/25, received by the facility 3/19/25 indicated R1 was	F 686		

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F 686	Continued From page 13 discharged with hospice services. There was no documentation of skin integrity. R1's nursing progress note dated 3/19/25, indicated R1 returned from the hospital. R1 signed onto hospice. R1's hospice plan of care dated 3/19/25, indicated R1's terminal diagnosis was acute hypoxic respiratory failure. Wound care order: Sacral wound and bilateral lower extremity wounds: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound skin. Cover with a foam bandage three times a week and as needed. Wound care was to be performed by the facility staff. R1's facility nursing readmit data collection dated 3/19/25, indicated under additional evaluation no pain was identified for R1. R1's skin condition indicated an area on the "coccyx." In the summary notes included, "wound to right buttock cover with foam dressing. Will continue to follow wound nurse. No monitoring, assessing, or any type of treatment was added to the care plan or the Treatment Administration Record (TAR) for this area on the coccyx. R1's nursing progress note dated 3/20/25, indicated the IDT met to review the weekly wounds to the abscess of his right gluteus. Wound improving. The note did not identify any new wounds as identified in the hospital record. The progress note did not address the pressure ulcers on his coccyx, left heel, right heel, or lateral right foot. R1's nursing progress note dated 3/21/25, indicated R1 refused his weekly skin assessment.	F 686		

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F 686	Continued From page 14 R1's significant change Minimum Data Set (MDS) dated 3/26/25 did not indicate a Brief Interview for Mental Status (BIMS) score, R1 was dependent on staff assistance with toileting, showering, dressing, personal hygiene, rolling in bed, bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were chronic congestive heart failure, opioid dependent, pain and chronic obstructive pulmonary disease. The MDS included there were no pressure ulcers or any other skin conditions or wounds to the feet. There was no mention of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot as identified by the hospital on 3/17/25. R1's nursing progress note dated 3/27/25, indicated IDT weekly wound review indicated R1's abscess of the right gluteus had been resolved. There was no assessment of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot. R1's electronic treatment administration records (eTAR) dated 4/1/25 - 4/27/25, indicated R1 was to have a weekly skin inspection. Wound cares to cleanse wound to right ankle with wound cleanser pat dry and apply foam gauze daily and as needed. Nurse to monitor and chart on resident picking at skin, scabs, wounds, if noted bleeding. If noted clean area and cover with bandage every day and evening shift. All treatments were marked as complete. The ulcer to his coccyx was not identified on the TAR. The pressure ulcers on R1's heels were not identified on the TAR either. No assessment of these areas was documented. R1's weekly skin inspection dated 4/4/25,	F 686		

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F 686	Continued From page 15 indicated R1 had the same old wounds, no new skin issues noted. No actual assessment of any area of his skin was documented. R1's nursing progress note dated 4/7/25, indicated the facility nurse spoke with RN-B from hospice and asked if he would be writing orders for R1's wounds to his right foot/ankle and he stated he would. Writer asked for a treatment order and wanted R1 to be added to the facility wound rounds. Hospice RN-B stated he would be coming the following day or the next and would assess the leg and write treatment orders. The provider was updated, and nurse will clean and dress wounds daily. R1's facility care plan dated 4/9/24 - 4/28/25, did not indicate any skin integrity concerns for R1. R1's nursing progress note dated 4/11/25, indicated wound treatment to right foot was completed with assistance from a fellow nurse. There was no mention of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot or any assessment of the right foot. R1's nursing progress note dated 4/17/25, indicated for nurses to please monitor and chart on R1 for picking at skin, scab's wounds. If noted bleeding if noted clean area and cover with bandage. There was no mention of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot. R1's weekly skin inspection dated 4/18/25, indicated R1 had no new skin issues. Ongoing wound care to his right foot. There was no assessment of any skin ulcers or skin conditions documented.	F 686		

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F 686	Continued From page 16 R1's nursing progress note dated 4/23/25, indicated for nurses to please monitor and chart on R1 for picking at skin, scab's wounds. If noted to be bleeding, clean area and cover with bandage. The following skin and wound evaluations and orders were completed during the survey process: -R1's skin and wound evaluation on 4/28/25 at 4:51 p.m., indicated R1 had a pressure ulcer (deep tissue injury) on his right medial malleolus (inside of the ankle) in-house acquired with an area 1.5 centimeters squared (cm), length 1.9 cm, width 1.1 cm. There was no documentation of the wound bed. -R1's Skin and wound evaluation on 4/28/25 at 4:56 p.m., indicated R1 had an unstageable (obscured full-skin and thickness skin and tissue loss) pressure ulcer on his right lateral (outside) foot in-house acquired. The wound area measured 4.3 cm, length 3.1 cm, width 1.8 cm, 0 depth, 60 % granulated (healing tissue in a wound bed), 40% slough (dead tissue and debris in a wound bed), light exudate (fluid in the wound, part of the healing process). -R1's skin and wound evaluation on 4/29/25 at 7:24 a.m., indicated R1 had unstageable pressure ulcer on his sacrum in-house acquired with an area of 32.9 cm, length 5.4 cm and with 7.8 cm, 0 depth. The wound was 50% granulated and 20% slough and 30% eschar (scab, dead cells). The wound had moderate serosanguineous exudate (mixture a watery bodily fluid and blood).	F 686		

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F 686	Continued From page 17 -R1's weekly skin inspection summary dated 4/29/25 at 7:57 a.m., indicated R1 had a pressure ulcer on his sacrum, left and right buttocks. Pressure wound on his right lateral malleolus. Pressure wound on his right lateral foot. Pressure wound on his right medial malleolus. Abrasion of his left dorsum (top) 5th toe. Abrasion of his right dorsum 2nd toe. Abrasion of his right dorsum 1st toe. The wounds were assessed by the in-house wound nurse and treatment completed. Hospice and medical provider updated, and treatment orders obtained. -R1's clinical physician orders dated 4/29/25, indicated R1 was to have wound care to his sacrum (left and right buttock) cleanse wound with wound cleanser pat dry, apply skin prep to peri-skin. Apply calcium alginate to wound bed and cover with foam. -R1's clinical physician orders dated 4/30/25, indicated R1 was to have wound care to his right later malleolus and right lateral foot. Cleanse wound with wound cleanser, pat dry, apply skin prep to peri-skin. Apply Calcium Alginate to wound bed and cover with foam dressing. -R1's clinical physician orders dated 4/30/25, indicated R1 was to have wound care to his right medical malleolus. Apply skin prep to discolored area. -R1's clinical physician orders dated 4/30/25, indicated wound care to left 5th toe, right 2nd toe and right 1st toe. Apply skin prep to scabbed areas and cover with bandage. Upon interview on 4/28/25 at 4:12 p.m., licensed	F 686		

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F 686	Continued From page 18 practical nurse, LPN-B stated she was unable to complete R1's readmission skin assessment because she was unable to reposition him to view his back. Since his readmission on 3/19/25 staff had difficulty completing cares on R1 because "touching him made him scream in pain." She did not reach out to hospice as they were completing their own visits with him. She had placed a foam dressing over R1's coccyx at some point. She did not chart placing the dressing because there were no orders for a dressing change and the wound was "small." She did not recall the last time she placed a dressing on his coccyx. LPN-B believed the wound care team or hospice was treating R1's skin. Upon interview on 4/29/25 at 8:55 a.m., nursing assistant (NA)-A stated she completed incontinence cares on R1, R1 would only let her reposition him when he needed cleaning following a bowel movement due to his pain. NA-A saw an open wound on R1's coccyx and at times the area had a dressing covering the area. She stated the dressing would be dirty and she would tell the nursing staff (unidentified staff and dates) and would be told the facility is not responsible for R1's skin. Upon interview on 4/29/25 at 10:04 a.m. hospice registered nurse, RN-B stated she was aware that R1 had a coccyx wound. She was not certain whether the facility had orders to tend to the wound or not. She was not aware of any heel or foot wounds. Upon interview on 4/29/25 at 11:14 a.m., family member (FM)-A stated she received a call from the facility on 4/28/25 that R1 had some "sores" and hospice should have been taking care of	F 686		

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F 686	Continued From page 19 them, but the facility found out they were not. FM-A was not told the location or severity of the wounds. She stated she wondered if that was why R1 had so much pain. R1 had been calling her almost daily crying in pain. FM-A mentioned his pain to the facility, she was told they were giving him everything they could. She stated on 4/25/25, R1 called her sobbing on the phone wanting to go to the hospital due to his pain. FM-A notified Hospice. FM-A stated she had not seen staff reposition R1. Every time she visited him, he had was laying in the same position, on his back, and he had only attempted to get out of bed once since his hospital discharge of 3/19/25. Upon interview on 4/29/25 at 11:49 a.m. RN-A stated during her weekly skin assessment she did not notice any pressure ulcers on R1, however repositioning him due to his pain made it difficult to visualize his skin. She stated she would not be measuring his wounds during an assessment as the facility has a wound team that takes care of all the measurements. She was unable to perform a full body assessment at any point due to pain. She did not notify hospice or the provider about this. Upon interview on 4/29/25 at 11:57 a.m. licensed practical nurse, (LPN)-A nurse manager stated she was not aware until the survey observation findings that R1 had any pressure ulcers. She stated she reviewed the hospice notes and stated hospice was responsible for R1's ADL's (activities of daily living) so if there were any wound care treatments they would be performing it. She did not communicate with the hospice nurses regarding R1's pressure ulcers. LPN-A did not know hospice was only providing care once a week and did not see the orders that R1 had	F 686		

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F 686	Continued From page 20 pressure ulcers. Upon interview on 4/29/25 at 4:37 p.m., hospice registered nurse, RN-A stated hospice does not complete wound care. He stated the orders were clear in R1's admission plan of care. That the facility was to complete the wound treatment. RN-A did not communicate with the facility about R1's skin because the hospice plan of care indicated the facility was completing R1's wound treatments. He assumed since the facility did not reach out to him there were no concerns with R1's skin. Upon interview on 4/30/25 at 11:30 a.m., the facilities Medical Director stated the facility is the main provider of care to the residents and must know who is providing any treatments. Upon interview on 4/30/25 at 2:14 p.m. the assistant director of nursing ADON stated he was the certified wound specialist for the facility. R1's skin condition was brought to his attention on 4/29/25 at around 4:45 p.m. He was able to assess R1's lower extremity wounds, but the facility could not manage R1's pain enough to assess his coccyx wound until the morning of 4/30/25. He ordered treatments for the wounds and reported the wounds to hospice. He stated he ordered daily dressing changes and hospice changed the orders to three times a week, Monday, Wednesday, and Friday. The ADON told hospice he wanted as needed order so the facility could also change the dressing, believing hospice was completing R1's treatments. He stated LPN-A told him upon his wound assessment that hospice was handling R1's wounds because they were doing his activities of daily living (ADL's).	F 686		

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F 686	Continued From page 21 R1's progress note dated 5/1/25 at 7:02 a.m. indicated R1 had passed away. An undated note found in R1's handwriting in his notebook found after his passing undated indicated "Thursday morning 7 a.m. convinced nurse to take bandage off lower back burning pain in lower back, bandage not looked at or attended for over 1 month." Upon interview and record review on 5/1/25 at 9:46 a.m. the director of nursing (DON) stated the nurse who completed R1's assessment did miss the wounds, however the wounds were the responsibility of hospice, so the facility would not "necessarily" have documented the wounds. The DON reviewed R1's hospice care plan indicating the facility was to be completing wound care and stated he never saw the hospice plan of care before and would need to investigate it. Upon interview and record review on 5/1/25 at 11:30 a.m., the Administrator stated the facility, and hospice provider should communicate to discuss the hospice resident, and the facility should document the communication. She would expect the facility to note and assess all wounds on their residents no matter who was completing the wound care. If during a facility assessment a wound was covered, she would expect the staff to remove the dressing if it were removable and assess the wound. The Administrator was not certain who was providing wound care for R1. The immediate jeopardy was removed on 5/2/25, when it was verified, the facility completed the following actions, on 5/2/25 The facility identified other residents at risk for pressure ulcers, reviewed policy, and procedures, and educated	F 686		

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F 686	Continued From page 22 staff on the following: -Completion of comprehensive skin assessments according to professional standards. -Developed care planned treatments and monitoring to accurately reflect resident needs. A facility policy titled Skin Assessment and Wound Management with a revised 2/2025 indicated Provide guidelines for assessing and managing wounds were: A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. Staff will perform routine skin inspections (with daily care). Nurses are to be notified if skin changes are identified. Licensed staff will complete a weekly skin inspection. 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: Notify Provider/Treatment Ordered. Notify resident representative. Complete education with resident/resident representative including risks & benefits. Initiate Skin and Wound Evaluation. Notify Nurse Manager/Wound Nurse. Referral to dietary, if appropriate. Referral to therapies, if appropriate. Review and update care plan including interventions. Update resident care lists. Update Care Plan to identify risks for skin breakdown. When a pressure ulcer is identified, the following	F 686		

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F 686	Continued From page 23 actions will be taken: Notify Provider/Treatment Ordered. Notify resident representative. Complete education with resident/resident representative including risks & benefits. Initiate Skin and Wound Evaluation. Notify Nurse Manager/Wound Nurse. Referral to dietary, if appropriate. Referral to therapies, appropriate. Review and update care plan including interventions. Update resident care lists. Update Care Plan to identify risks for skin breakdown. Follow ongoing treatments per provider order. Update provider and resident/representative as needed. Update care plan as needed.	F 686		
F 697 SS=J	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility did not ensure a residents pain was managed in accordance with professional standards of practice and hospice plan care, for 1 of 3 residents (R1) reviewed for pain. R1's medication regimen was ineffective; he would scream and moan in pain contacting EMS and his daughter for help. This resulted in immediate jeopardy (IJ) when the facility did not have a system in place to manage R1's pain causing R1 unnecessary physical and psychological harm. The immediate jeopardy began on 4/1/25 when	F 697	R1 passed away on 05/01/2025. Like-residents at risk for uncontrolled pain have had a comprehensive assessment completed and plan of care to match with the resident’s goals and preferences. Orders were added to the residents’ plan of care on how and when to monitor the resident’s symptoms and degree of pain relief. All residents have the potential to be affected by this deficient practice.	5/5/25

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F 697	Continued From page 24 R1's pain medication became ineffective and subsequently lacked follow-up of effectiveness, the patient called emergency services for pain medication, and called his daughter crying in pain, and was identified on 4/28/25. The Administration, director of nursing, and regional nurse manager were notified of the immediate jeopardy at 5:10 p.m. on 5/1/25. The immediate jeopardy was removed on 5/2/25, but noncompliance remained at the lower scope of and severity level 2, D - isolated, which indicated no actual harm with potential for more than minimum harm that is not immediate jeopardy. Findings include: R1's facility care plan dated 9/6/24 - 4/28/25 did not have any pain focus, goals, or interventions. R1's quarterly Minimum Data Set (MDS) dated 2/6/25 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 14 indicting R1 was cognitively intact. R1's providers orders dated 2/24/25 indicated staff was to monitor R1 for pain daily on every shift. Staff was to provide non-pharmacological pain interventions. 1. Ice 2. Heated blankets 3. Massage 4. Repositioning 5. Music 6. Essential oils 7. Food and drink 8. Relaxation and breathing. R1's nursing progress notes dated 3/17/25 - 4/28/25 did not indicate any documentation that the facility communicated R1's pain levels with the hospice agency. R1's hospital discharge summary dated 3/18/25, received by the facility 3/19/25 indicated R1 was	F 697	Education was provided to nursing staff on the Monarch Pain Policy, including collaboration with provider when pain relieving efforts are not effective, determining resident's goals and preferences to manage the pain. Nursing staff will be educated on how to identify signs and symptoms of pain and monitoring appropriately for effectiveness of resident's specific pain management regimen. Nursing will collaborate with the provider if pain management is not effective and try other pain alternatives for relief. The DON or designee will complete audits on 5 random residents weekly x 4 and then monthly x2 and then review at QAPI to adjust frequency as indicated by audit data. Audits will include reviewing resident pain ratings to ensure that resident's current pain management regimen is effective. If identified that current medications and non-pharm methods are ineffective, provider has been notified, new orders obtained, and care plan updated to reflect changes. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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F 697	Continued From page 25 discharged with hospice services. He was discharged with the comfort medications hydromorphone 2 mg 1 tablet as needed every three hours for pain (narcotic pain medication) this was changed by hospice on 3/22/25. R1's hospice plan of care dated 3/19/25 indicated R1 was admitted to hospice with a terminal diagnosis of acute hypoxic respiratory failure. R1's medications orders were hydromorphone 2 mg every hour as needed (PRN) for pain. Gabapentin 300 (2 tablets) scheduled for three times a day for pain and Acetaminophen 500 mg 2 tablets scheduled for three times a day for pain. R1's hospice goals were to monitor pain and use/effectiveness of prn hydromorphone and patient/caregiver will report pain and or below patient's desired level of (0-3/10) using the standardized scale of (0-10 where 0 in no pain and 10 is the greatest pain ever felt.) If patient's pain exceeded the level of his goal, appropriate interventions would be initialed by an encounter to return to patient's desired level of pain. R1's facility Readmission Data Collection assessment dated 3/19/25 had a blank entry under the title additional evaluation for pain and description. No other pain assessments were documented. R1's hospice providers orders dated 3/20/25 indicated R1 was to take scheduled Buprenorphine HCl-Naloxone HCl Sublingual 4 mg / 1 mg film (a narcotic pain medication often used for patients with opioid addiction) give 1 mg scheduled three times a day for pain. R1's eMAR dated 3/20/25 indicated R1's pain	F 697		

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F 697	Continued From page 26 levels administration of Hydromorphone was a 6 at 9:06 a.m. and was documented as effective, at 4:49 p.m. his pain was an 8 and documented as effective. The eMAR did not indicate how many tablets of Hydromorphone R1 had taken. Under R1's Buprenorphine HCl-Naloxone scheduled three times a day for 8:00 a.m. 2:00 p.m. and 8:00 p.m. R1's pain was at 8:00 am was a 6 at 2:00 p.m. his pain was a 4 and at 8:00 p.m. his pain was a 0. R1's eMAR dated 3/21/25 at 2:35 p.m. indicated R1 was given a prn Hydromorphone 2 mg for a pain level of 8 documented as effective. The eMAR did not indicate how many tablets were administered. Under R1's Buprenorphine HCl-Naloxone administration R1's pain was a 4 at 8:00 a.m., a pain of 8 at 2:00 p.m. and a pain of 8 at 8:00 p.m. R1 was not given any as needed (prn) medication for his pain levels ranging from 4-8. R1's eMAR dated 3/22/25 at 10:09 a.m. indicated R1's was given a prn Hydromorphone 2 mg for a pain level of an 8 and documented as effective, at 1:09 p.m. his pain level was a 9 and was not effective. He given another prn dose of Hydromorphone at 1:09 p.m. The eMAR did not indicate how many tablets R1 was given. Under R1's Buprenorphine HCl-Naloxone documentation R1's pain was an 8 at 8:00 a.m., a pain of 8 at 2:00 p.m. and a pain of 8 at 8:00 p.m. R1's eMAR dated 3/23/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone documentation R1's pain was a 9, at 2:00 p.m. his pain was 8 and at 8:00 p.m. his pain was a 3. There was no documentation of effectiveness when medication given. R1 was not given a prn pain medication	F 697		

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Hydromorphone for his pain levels of an 8 and 9.

R1's eMAR dated 3/24/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone administration R1's pain was a 6, at 12:00 p.m. a pain of 0, and at 8:00 p.m. a pain of 0. There was no documentation of effectiveness when medication given. R1 was not given a prn narcotic when his pain level was a 6.

R1's eMAR dated 3/25/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone administration R1's pain was a 0, at 12:00 p.m. his pain was a 7, at 8:00 p.m. his pain was a 2. There was no documentation of effectiveness when medication given.

R1's eMAR dated 3/26/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone administration R1's pain was 0 at 8:00 a.m., at 12:00 p.m. his pain was a 4, at 8:00 p.m. his pain was a 2. There was no documentation of effectiveness when medication given.

R1's significant change MDS dated 3/26/25, identified frequent pain rated at an 8 out of 10 which occasionally interfered with day-to-day activities. However, this was not added to the care plan.

R1's eMAR dated 3/27/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone administration R1's pain was an 8, his pain was a 0 at 4:00 p.m., and his pain was a 3 at 8:00 p.m. There was no documentation of effectiveness when medication given. No prn medication was given when his pain level was an 8.

R1's eMAR dated 3/28/25 at 8:00 a.m. under R1's

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Buprenorphine HCl-Naloxone administration. R1's pain was documented as an "x" at indicating to read progress note, at 4:00 p.m. documentation was also an "x" indicating to read progress note. At 8:00 p.m. his pain level was a 3. There was no documentation of effectiveness when medication given.

R1's eMAR dated 3/29/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone administration R1's pain was a 0, at 4:00 p.m. his pain was a 4, at 8:00 p.m. his pain was a 7. There was no documentation of effectiveness when medication given. A prn pain medication was not given when his pain level was a 7.

R1's eMAR dated 3/30/25 under R1's Buprenorphine HCl-Naloxone administration R1's pain was a 0 at 8:00 a.m., 4 p.m., and 8:00 p.m.

R1's eMAR dated 3/31/25 at 8:00 a.m. under R1's Buprenorphine HCl-Naloxone administration R1's pain was a 9, at 4:00 p.m. his pain was a 4 and at 8:00 p.m. his pain was an 8. There was no documentation of effectiveness when medication given. No prn pain medication was given when his pain levels were an 8 and a 9.

R1's electronic medication record (eMAR) dated 4/1/25 at 8:00 a.m. indicated R1's pain level was 0. At 8:43 a.m. R1's pain level was a 4 and was given a prn dose of Hydromorphone 2 mg. R1's follow-up indicated the medication was ineffective. At 2:47 p.m. R1's pain was an 8 and he was given Hydromorphone 2 mg, and the follow-up indicated the medication was effective. At 4:35 p.m. R1's pain was an 8 and he was given prn dose of Hydromorphone 2 mg and his pain follow-up indicated effective. At 7:00 p.m.

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(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 697	Continued From page 29	F 697		

R1's pain level was an 8 and was given a prn dose of Hydromorphone 2 mg and the pain follow-up was documented as effective.

R1's providers orders dated 4/2/25 indicated R1 used a Lidocaine patch non-narcotic pain patch) 4% lidocaine 1 patch on his hip and one patch on his knee daily.

R1's eMAR dated 4/2/25 at 7:25 a.m. indicated R1's pain level was an 8 and was given a prn dose of Hydrocodone 2 mg the follow-up indicated the medication was effective. At 10:28 a.m. his pain level was a 7 and was given a prn dose of Hydrocodone 2 mg and the medication was effective. At 3:42 p.m. R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and documented as effective.

R1's eMAR dated 4/3/25 at 5:25 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 10:23 p.m. R1's pain level was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as effective.

R1's eMAR dated 4/4/25 at 6:23 a.m. indicated R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given R1's follow-up relief was documented as unknown. At 12:22 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 1:24 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 3:23 p.m. R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 7:48 p.m. R1's pain was a 7 and a prn dose of Hydromorphone 2 mg

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	245295	A. BUILDING _____ B. WING _____	C 05/05/2025

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F 697	Continued From page 30 was given and documented as effective. R1's eMAR dated 4/5/25 at 11:36 a.m. indicated R1's pain was a 9 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 1:11 p.m. R1's pain was a 9 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 3:47 p.m. R1's pain was a 4 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 9:12 p.m. R1's pain was a 4 and a prn dose of Hydromorphone 2 mg was given and documented as effective. R1's eMAR dated 4/6/25 at 7:51 a.m. indicated R1's pain was 9 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 1:50 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 6:25 p.m. R1's pain level was a 0 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 7:12 p.m. R1's pain level was a 4 and a prn dose of Hydromorphone 2 mg was given, and the results were documented as unknown. R1's nursing progress note dated 4/6/25 at 6:36 indicated R1 had called the Administrator asking for help instead of using his call light or asking for help from the nursing assistant or nursing staff. R1 denied pain, his vitals were normal, and he was offered an ice pack, and his prn hydromorphone was administered. R1's eMAR dated 4/7/25 at 4:38 a.m. indicated R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and the resulted were documented as unknown. At 8:25 a.m. R1's	F 697		

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F 697	Continued From page 31	F 697		

pain level was a 7 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 10:25 a.m. R1's pain level was a 7 and a prn dose of Hydromorphone 2 mg was given and documented at ineffective. At 11:35 a.m. R1's pain was a 7 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 1:50 p.m. R1's pain was a 7 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 5:31 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 7:00 p.m. R1's pain level was 5 and a prn dose of Hydromorphone 2 mg was given, and his pain was documented as effective.

R1's eMAR on 4/8/25 at 9:51 a.m. R1's pain was a 9 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 2:15 p.m. R1's pain level was a 9 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 9:07 p.m. R1's pain was a 5 and a prn dose of Hydromorphone 2 mg was given and documented as effective.

R1's eMAR dated 4/9/25 at 8:08 a.m. indicated R1's pain was a 0 and a prn dose of Hydromorphone 2 mg was given. At 2:55 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 7:07 R1's pain was a 5 and a prn dose of Hydromorphone 2 mg was given and documents as effective.
R1's eMAR dated 4/10/25 at 4:49 p.m. R1's pain was a 4 and a prn dose of Hydromorphone 2 mg was given and documented as effective.

R1's eMAR dated 4/11/25 at 5:33 a.m. indicated

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F 697	Continued From page 32 R1's pain was a 10 and a prn dose of Hydromorphone 2 mg was given and documents as effective. At 8:18 a.m. R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 3:20 p.m. R1's pain was a 7 and a prn dose of Hydromorphone 2 mg was given and documented as effective. R1's eMAR dated 4/12/25 at 4:49 p.m. indicated R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and was documented as effective. At 11:16 a.m. R1's pain was a 5 and documented as ineffective. At 6:02 p.m. R1's pain was a 9 and a prn dose of Hydromorphone 2 mg was given and documented as effective. R1's eMAR dated 4/13/25 at 6:12 a.m. R1's pain was a 9 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 7:30 a.m. R1's pain was a 10 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 9:29 a.m. R1's pain was a 10 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 11:03 a.m. R1's pain was a 10 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 1:05 p.m. R1's pain was a 10 and a prn dose of Hydromorphone 2 mg was given and documented as effective. R1's nursing progress note dated 4/13/25 at 6:15 a.m. indicated at approximately 6:05 a.m. emergency medical transport (EMT) showed up for R1's room and stated a resident called and gave them a room number. Staff checked on R1 and asked if he called (EMT) R1 was watching pictures on his phone and stated he had called EMT so he could get his pain medications as	F 697		

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F 697	Continued From page 33 soon as he woke-up. EMT spoke with R1, he did not want to go the hospital, he just wanted his pain medications. R1 did not use his call light to call the staff. R1 rated his pain a 9/10 and was given his Hydromorphone 2 mg. R1's eMAR dated 4/14/25 at 6:12 a.m. R1's pain was a 5 and a prn dose of Hydromorphone 2 mg was given and was documented as effective. At 1:31 p.m. R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and was documented as effective. At 5:22 p.m. R1's pain was a 6 and a prn dose of Hydromorphone 2 mg was given and documented as effective. R1's nursing progress note dated 4/14/25 at 11:46 by Social Services indicated Social Services was called by staff who were providing care to observe and support as needed. It was observed that R1 was expressing pain even before staff initiated any physical contact, indicating a high level of sensitivity. Staff were observed to be careful and communicated with R1 throughout each step of the care process. They demonstrated patience and empathy, ensuring that the resident felt as comfortable as possible despite his ongoing pain. At the conclusion of care, R1 appeared more settled and was made comfortable by the staffs attentive approach. The note did not identify whether Social Services communicated with nursing management or hospice. R1's eMAR dated 4/15/25 at 9:00 a.m. R1's pain was a 10 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 10:12 a.m. R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and documented as effective. At 11:49 a.m. R1's pain	F 697		

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F 697	Continued From page 34 was an 8 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 3:10 p.m. R1's pain was an 8 and a prn dose of Hydromorphone 2 mg was given and documented as ineffective. At 8:30 p.m. R1's pain was a 7 and a prn dose of Hydromorphone 2 mg was given and documented as effective. R1's providers orders dated 4/16/25 indicated R1 was to take Hydromorphone HCl (a narcotic pain medication) 2 mg 1.5 tablets. This was increased from 1 tablet every hour as needed to 1.5 tablets (3 mg) as needed for pain. R1's eMAR indicated on 4/16/25 R1 was to have Hydromorphone HCl 2 mg scheduled every 4 hours for pain. 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. R1 was given his pain medication at 12:00 a.m. with a pain level of 0 and 04:00 a.m. with a pain level of 0, at 8:00 a.m. with a pain level of 5, at 12:00 p.m. with a pain level of 8, 4:00 p.m. at 8, 8 p.m. at 4. R1's eMAR indicated on 4/17/25 R1 was to take Hydromorphone HCl 2 mg 1.5 tablets every hour by mouth as needed for pain. If medication was not helping enough after 3 doses in a row to call hospice. R1's was given medication at 12:00 a.m. and his pain level was 5, at 4:00 a.m. his pain was a 5, at 8:00 a.m. his pain was a 5, at 12:00 p.m. his pain was a 5, at 2:28 p.m. R1's pain level was a 5 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3 mg was given and documented as ineffective, at 4:00 p.m. his pain was a 6 at 8:00 p.m. his pain was a 0. R1 was not administered any prn Hydromorphone until 2:28 p.m. even though his pain levels were a 5 prior to that dose.	F 697		

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F 697	Continued From page 35 R1's eMAR dated 4/18/25 at 12:00 a.m. R1's pain level was a 2, at 4:00 a.m. his pain was a 3, at 8:00 a.m. his pain was a 5, at 12:00 p.m. his pain was a 3 and at 4:00 p.m. his pain was a 6, at 6:15 p.m. R1's pain level was a 6 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3 mg was given and documented as ineffective. At 8:00 p.m. R1's pain remained at a 6 without any additional prn medication administered. R1's eMAR dated 4/19/25 indicated at his levels with his schedules hydromorphone at 12:00 a.m. R1's pain was a 3, at 4:00 a.m. his pain was a 3, at 8:00 a.m. his pain was 3, at 12:00 p.m. his pain was a 5, at 4:00 p.m. his pain was a 6, at 8 p.m. his pain level was a 6. No prn Hydromorphone was administered even though R1's pain ranged between a 3 and an 8. R1's eMAR dated 4/20/25 indicated R1's pain levels with his scheduled medications were at 12:00 a.m. the pain was a 0, at 4 a.m. the pain was a 0, at 8 a.m. the pain was a 0, at 12:00 p.m. the pain was a 0, at 1:43 p.m. R1's pain was a 10 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3 mg was given and documented as effective. At 2:00 p.m. his pain was a 6, at 8:00 p.m. his pain was a 6. No further prn doses were administered even though R1's pain continued to be a 6. R1's eMAR dated 4/22/25 indicated R1's pain level with his scheduled doses of Hydromorphone indicated at 12:00 a.m. pain was a 0, at 4:00 a.m. pain was 0, at 8:00 a.m. pain was a 0 at 12:00 p.m. Hydromorphone was held, pain level was not indicated, at 4:00 p.m. pain level was a 6, at 8:00 p.m. pain level was a 6. No prn doses of	F 697		

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F 697	Continued From page 36 hydromorphone were administered even though R1 had pain levels of 6. R1's eMAR dated 4/23/25 indicated R1's pain levels with scheduled doses of hydromorphone at 12:00 a.m. pain was 0 at 4:00 a.m. pain was a 0 at 8 a.m. pain was held at 12:00 p.m. pain level was a 5, at 4:00 p.m. pain level was a 5 at 5:00 p.m. indicated R1's pain level was a 10 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3 mg was given and documented as effective. At 8:00 p.m. R1's pain level was a 6. At 8:43 p.m. R1's pain level was a 5 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3 mg was given and indicated as effective. R1's eMAR dated 4/24/25 indicated R1's pain levels with scheduled doses of Hydromorphone at 12:00 a.m. pain was a 0, at 4:00 a.m. pain was a 0, at 8:00 a.m. pain was a 3, at 12:00 pain was a 4, at 4:00 p.m. pain was a 5, at 8:00 p.m. pain was a 0. No prn Hydromorphone was administered even though pain levels reached a 5. R1's eMAR dated 4/25/25 indicated R1's pain levels with scheduled doses of Hydromorphone at 12:00 a.m. pain was 0, at 4 a.m. pain was 0, at 8:00 a.m. pain was a 4, at 12:00 p.m. pain was a 5, at 4:00 p.m. pain was a 4, at 8:00 p.m. pain was not identified, and medication was refused. R1's eMAR dated 4/26/25 indicated R1's pain levels with scheduled doses of Hydromorphone indicate at 12:00 a.m. pain was a 5, at 4:00 a.m. pain was a 0 at 8:00 a.m. pain was a 0 at 12:00 p.m. pain was pain was a 4, at 2:59 p.m. indicated R1's pain was a 9 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3	F 697		

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F 697	Continued From page 37 mg was given and documented as effective. At 1:00 p.m. pain was a 9, at 8:00 p.m. pain was a 5. R1 was not administered additional prn Hydromorphone when his pain level continued to be a 9 and then a 5. R1's eMAR dated 4/27/25 indicated R1's pain levels with schedules doses of Hydromorphone at 12:00 a.m. pain was a 0, at 4:00 a.m. pain was a 0, at 8:00 a.m. pain was a 0 and 12:00 p.m. pain was an 8, at 4:00 p.m. pain was 0, at 8 p.m. pain was a 0. R1 was not administered a prn Hydromorphone when his pain level was an 8. R1's eMAR dated 4/28/25 indicated R1's pain levels with scheduled doses of Hydromorphone at 12:00 a.m. pain was a 0, at 4:00 a.m. pain was a 0. At 8:00 a.m. pain was a 0, at 12:00 p.m. pain was a 5 at 4:00 p.m. pain was a 5, at 6:22 p.m. indicated R1's pain was an 8 and a prn dose of Hydromorphone 2 mg (1.5 tablets) for a total of 3 mg was given and documented as effective. At 8:00 p.m. R1's pain was an 8. R1's pain continued at an 8 and no prn Hydromorphone was administered. Upon observation and interview on 4/28/25 at 3:39 p.m. R1 was on his back in a hospital bed wearing a hospital gown telling a friend about his back pain. R1 agreed to a skin inspection, but stated he was in so much pain it caused severe pain to move him. He requested the assistance of three staff members and requested they move him slowly. R1 had dried blood on all five toes of his right foot. The second toe of his right foot had a dirty bandage on it. R1's sheet was pulled back and pressure ulcers were observed on both heels, and a pressure ulcer on his right lateral foot. Staff attempted to roll R1 onto his left side.	F 697		

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F 697	Continued From page 38 R1 screamed in pain and gripped the side rail. He was screaming for staff to stop. He was laid back on this back. R1's coccyx area appeared red, it was difficult to visualize and make an assessment as R1's pain level was so great the staff had to reposition him back on his back within seconds. At 3:58 LPN-B gave R1 a pain medication. At 5:00 p.m. R1 continued to state his pain was a 10/10 and staff was still unable to move him. R1 was not offered any addition management for his pain. The director of nursing (DON) was notified, and the staff began to assess R1's skin and pain. R1 did not have a lidocaine pain patch on his right up or knee. Upon interview on 4/28/25 at 4:12 p.m. licensed practical nurse, LPN-B stated since his readmission on 3/19/25, staff had difficulty completing cares on R1 because touching him made him scream in pain. She stated she did not reach out to hospice as they were completing their own visits with him, and her job was to follow their orders which included giving as needed pain medications. R1's facility care plan dated 4/29/25 (during the survey process) indicated R1 had an alteration in comfort related to a history of pain and closed fracture of the right acetabulum and wound to coccyx. R1's goals were to have adequate relief from pain as evidenced by verbalization, and freedom from signs/symptoms of nonverbal indicators of pain. Upon interview on 4/29/25 at 8:55 a.m. nursing assistant (NA)-A stated she completed incontinence cares on R1; however, he would only let her reposition him when he required cleaning following a bowel movement because	F 697		

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F 697	Continued From page 39 moving him was too painful. She reported his pain to nursing staff (unidentified staff and unidentified dates), she was told that R1 was on hospice, and they handle his pain. Upon interview on 4/29/25 at 10:04 a.m. hospice registered nurse, RN-B stated she was at the facility completing an unscheduled visit because R1's family had reached out to hospice regarding R1's pain. RN-B made changes to R1's pain regimen. She was going to include ketamine injections to assist in controlling R1's pain if approved by her superiors at hospice. Upon interview on 4/29/25 at 11:57 a.m. licensed practical nurse, LPN-A nurse manager stated staff should be reporting uncontrolled pain to hospice and to her. She stated staff were to following-up and indicate if pain had resolved after they administer a pain medication. She was not certain if R1's pain regimen was effective. She stated Hospice was responsible for his pain control. LPN-A denied reaching out to Hospice regarding R1's pain and was not aware R1's family had spoken with staff regarding R1's pain control. Upon interview and record review on 5/1/25 at 9:46 a.m. the DON stated hospice oversaw R1 since his re-admission on 3/19/25. He stated there was a "fine line" for what pain medications would be covered so the facility had to use what hospice provided for R1. R1 was a former opioid addict; therefore, no matter how much medication the facility gave him he would ask for more. Upon interview and record review on 5/1/25 at 11:30 a.m. the administrator stated If a resident were in so much pain that cares could not be	F 697		

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F 697	Continued From page 40 performed, she would expect staff to reach out to the provider, hospice or the regular provider if hospice were not involved and the nursing management would be aware and try to implement other measures to control the pain. Upon interview on 5/1/25 at 10:30 a.m. hospice supervisor, RN-F stated on 4/25/25 R1's daughter called hospice complaining of R1 calling her constantly and crying in pain and being told by the facility they were giving R1 everything they could for his pain. On 4/28/25 hospice RN-E visited R1 and increased his pain medications. A nursing progress note dated 5/25/25 indicated R1 had passed away. An undated note in R1's handwriting found in his notebook after his passing indicated, "took last pain pill at 8:00 a.m. why can they send a man to the moon, yet still not stop a man from acute pain physical and mental." An undated note in R1's handwriting found in his notebook after his passing indicated, "Minnesota adult reporting center 1-844-884-1574." An undated note in R1's handwriting found in his notebook after his passing indicated, "further duration or stronger frequency, NO MORE PAIN." An undated note in R1's handwriting found in his notebook after his passing indicated, "Others do not want to get involved with me because I need to get some help from others and management will not participating in facilitating that." A facility policy regarding pain was requested however none provided.	F 697		

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F 697	Continued From page 41 The immediate jeopardy was removed on 5/2/25, the facility took immediate action to identify other residents at risk for uncontrolled pain, to reviewed policy and procedures, and educated staff on the following on 5/2/25 Manage or prevents pain: -Consistent with the comprehensive assessment and plan of care. -Current professional standards of practice. -Along with the resident's goals and preferences. -Monitored appropriately for effectiveness. -Defined how and when to monitor the resident's symptoms and degrees. but noncompliance remained at the lower scope and severity level 2 with a scope of D which indicated no actual harm with potential for no more than minimal harm that is not immediate jeopardy.	F 697		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions	F 700		5/28/25

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F 700	Continued From page 42 are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to attempt alternative devices before the use of bedrails on residents beds, assess the residents for risk of entrapment, ensure bed dimensions were appropriate for 2 of 2 residents (R1, R2) reviewed for bed rails. In addition, the facility failed to use caution as R1 had bed rails used in conjunction with an air mattress. Findings include: Food and Drug Administration (FDA) guidelines "Recommendations for Health Care Providers about Bed Rails" 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any	F 700	R1 passed away on 05/01/2025. R2's bed was inspected and bedrails tightened. R2's Bed Mobility Device form was reviewed and remains accurate. Full-house audit conducted on resident bed and bedrails, air mattresses, and risk for entrapment. Residents' beds and bedrails are inspected monthly by maintenance through the TELS Work Order system. All residents have the potential to be affected by this deficient practice. Education provided to staff regarding Bed Mobility Device Process, bedrails, air mattresses, and risk for entrapment. Maintenance or designee to complete random audits of resident beds to ensure the resident is not at risk for entrapment weekly times 4 weeks. Audit results to be brought to QAPI for further review and recommendation.	

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F 700	Continued From page 43 kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Retrieved from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm Food and Drug Administration (FDA) guidelines "Recommendations for Health Care Providers Using Adult Portable Bed Rails" 2023 indicated be aware that not all bed rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement, or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. Retrieved from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails. R1's Bed Mobility Device Evaluation dated 2/4/25 indicated R1's had grab bars due to his	F 700		

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F 700	Continued From page 44 preference. R1 did not use the device to assist with transfers, or to reposition in bed. The grab bars did not restrict the residents freedom of movement. R1 was able to demonstrate the appropriate use of the grab bars. The evaluation did not indicate what type of bed rails were being used, measurements or risks of entrapment. No alternatives had been attempted prior to the placement. The device assessments did not indicate the use of the air mattress with the bed rails or any precautions. R1's quarterly Minimum Data Set dated 2/6/25 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 14 indicting R1 was cognitively intact. R1's significant change dated 3/26/25 did not indicate a BIMs score R1 was dependent on staff assistance with toileting, showering, dressing, personal hygiene, rolling in bed, bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were chronic congestive heart failure, opioid dependent, pain and chronic obstructive pulmonary disease. Bed rails were not identified as used on the MDS. R1's care plan dated 4/28/25 did not indicate the use of bed rails or an air mattress. Upon observation and interview on 4/28/25 at 12:35 p.m. R1 was resting in bed. R1 had an air mattress and bilateral halo bed ails (circular shaped bed rails) at the head of his bed. R1 stated he started on hospice about six weeks ago and received the hospital bed, the air mattress, and the bed rails. R1 stated he used the rails to help reposition himself while in bed and to	F 700		

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F 700	Continued From page 45 prevent falling from his bed. He stated he would not be able to remove the rails from the bed on his own. R2's annual MDS dated 3/20/25 indicated R2's BIMs score was a 13 indicating R2 was cognitively intact. R2 required moderate assistance with toileting and rolling from left to right in bed. He required maximum assistance with dressing, bathing, and transferring. R2's pertinent diagnoses were hemiplegia following cerebral vascular disease (stroke followed by weakness or partial paralysis on one side of the body) and cardiomyopathy (heart disease of the muscle that affects its ability to pump blood). R2's MDS did not indicate a bed rail were used. R2's care plan dated 5/5/25 did not indicate the use of bed rails. R2's Bed Mobility Device Evaluation dated 3/16/25 indicated R2 had grab bars per his preference. The risk and benefits were explained. R2 used the grab bars for transferring due to left sided weakness. No alternative devices or methods were attempted prior to placement of the device. Upon observation and interview on 4/29/25 at 12:16 p.m. R2 was lying in bed he had bilateral quarter rails at the head of his bed. He stated he uses the rails transfer from his bed to his chair. Upon interview on 4/29/25 at 3:55 a.m. nursing assistant, NA-A stated she was not aware that bed rails could be a safety concerns for residents. She stated R1 used them to grip when he is having pain and when he repositions himself in bed. R2 used the rails to transfer out of the bed.	F 700		

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F 700	Continued From page 46 NA-A denied any training on the use of any kind of rails. Upon interview on 4/29/25 at 11:57 a.m. licensed practical nurse, (LPN)-A stated the facility completed quarterly bed mobility devices. LPN-A stated she not aware that there could be a concern when bed rails are used in conjunction with an air mattress. She denied knowledge of needing to try and document alternative methods before using bed rails. She was not certain if maintenance measured the zones of the grab bars, or if she should be measuring bed rail zones on her assessments. Upon interview on 4/29/25 at 2:14 p.m. the assistant director of nursing (ADON) stated the facility does not use bed rails they use grab bars, so the facility was not required to follow regulations for having bed rails. He denied awareness that R1 had halo rails with an air mattress and stated the hospice provided their own equipment, not the facility. Upon interview on 4/30/25 at 1:44 p.m. the director of maintenance stated he was not aware that R1 had a halo along with an air mattress. He did not assemble R1's hospital bed nor had he checked on it. He checks beds when staff initiates a message into the TELS system (the buildings services messaging system for updates and repair notifications), or he is prompted to complete a facility check per TELS. He stated he does a verbal assessment monthly on bed rails and a physical check on the bed rails quarterly. A verbal assessment meant he asked nursing staff if there were any concerns with any of the rails and a physical assessment meant he would actually look at the rails. He confirmed he did not	F 700		

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F 700	Continued From page 47 measure the bed rails for zone safety upon implementation of the rails. Upon interview on 5/5/25 at 2:40 p.m. the director of nursing, DON stated the facility did not have bed rails they only used grab bars, and the grab bars were all assessed upon implementation. Grab bar risks and benefits education was completed on a quarterly basis. He stated the facility uses grab bars therefor they would not be considered a restraint and no alternative method needed before being put into use. The pressure mattress (air mattress) manufacturer's instruction manual undated indicated: Due to concerns over the possibility of patient entrapment, the use of rails of any length is a matter currently addressed by federal and state laws/guidelines, and by individual facility protocol. It is the responsibility of the facility to be in compliance with these laws, which typically require that decisions on the use of bed rails of any type are based on assessment of the physical and mental status of each patient individually. If the patient needs bedrails to prevent fall-related injury, as determined by this facility assessment, we recommend that the bedrails be locked in the up position at all times. We do not require use of bedrails unless the patient is deemed to be safer with them than without them. The halo rails manufacturer instructions indicated undated indicated: Mattress must remain in firm contact with the Halo Safety Ring on both sides of the bed. If a Halo Safety Ring is only installed on one side of the bed, the mattress must remain in firm contact with the mattress stay or mount bracket on the other side of the bed. Proper	F 700		

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F 700	Continued From page 48 patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. Variations in mattress thickness, size or density could increase the risk of entrapment. Visit the FDA website at http://www.fda.gov to learn about the risks of entrapment. The bed rails manufacture manual undated indicated to regularly check the Halo device to identify areas of possible entrapment, immediately cease using the bed until entrapment risk is fixed. Regularly check to make sure that there is no gap between the Halo Safety Ring and the side of the mattress. A gap could allow the user to become wedged between the bed rail and the mattress. Follow all assembly instructions carefully. Failure to follow the instructions could result in serious injury to the user(s) of the product. The quarter bed rail manufacturer guide undated indicated a routine inspection was to include Risk of serious injury or death. Use a properly sized mattress to minimize the gap between the side of the mattress and the assist rail. This gap must be small enough to prevent a resident from getting their head or neck caught in this location. Make sure raising or lowering the bed, or articulating the sleep surface, does not create hazardous gaps. Failure to do so could result in serious injury or death. This assist rail is only one part of your healthcare bed system. Proper combinations of bed, mattress, head/foot panels and assist rails are needed to minimize the risk of entrapment. For more information, contact your representative. A facility policy titled Safe Medical Device dated	F 700		

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F 700	Continued From page 49 3/2009 indicated the definition of a medical device, the malfunction of the device, a reportable event, and serious injury. The policy did not include the assessment for restraints, need for alternative methods attempted or the risk for entrapment assessment.	F 700		
F 849 SS=J	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide.	F 849		5/5/25

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F 849	Continued From page 50 (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms	F 849		

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F 849	Continued From page 51 associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is	F 849		

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F 849	Continued From page 52 responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.	F 849		

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F 849	Continued From page 53 §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to establish a communication process between the facility and the hospice provider to ensure that the needs of a resident were addressed and met for 1 of 3 residents (R1) reviewed for hospice services. This resulted in an immediate jeopardy (IJ) when R1 did not receive the necessary care and services for the treatment of pressure ulcers and pain management. R1's pressure ulcer went untreated for approximately six weeks and R1's pain was not controlled, limiting staff's ability to perform activities of daily living for R1. In addition, the facility failed to have a designated member of the interdisciplinary team who was responsible to work with hospice to ensure residents receiving hospice services needs were met. The immediate jeopardy began on 3/19/25, when R1 was signed on to hospice services, was noted to have pressure ulcers and uncontrollable pain with no process in place to determine who was responsible to ensure R1's need were met. The Administration, director of nursing, and regional nurse manager were notified of the immediate jeopardy at 5:10 p.m. on 5/1/25. The immediate jeopardy was removed on 5/2/25, but noncompliance remained at the lower scope and severity level 2 D - isolated scope and severity	F 849	R1 signed onto hospice 03/19/2025. R1 passed away on 05/01/2025. Like-residents were identified, and their care plans were updated, if needed, to integrate with hospice care plan. Hospice agreements were reviewed with no identified changes needed. Review of the hospice policy and procedures was completed with no changes made at this time. The facility identified Erin King-McCray, social services, as the designated individual who will be responsible for working with hospice representatives to coordinate care that is provided to the resident by both facility and hospice staff. Facility staff and hospice providers were notified of this designation. Like-residents have the potential to be affected by this deficient practice. DON or designee educated nursing staff and IDT regarding hospice policy, notification of change policy, facility being primary caregivers of residents receiving hospice, following the pain education/process for provider notification	

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F 849	Continued From page 54 level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's quarterly Minimum Data Set dated 2/6/25, indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 14, indicting R1 was cognitively intact. R1's facility care plan dated 9/6/24, added a focus on 4/17/25 - one month after R1's admission to hospice - for hospice cares related to end stage disease process. The goal was for resident and family to receive comfort cares as desired. Interventions included communication with hospice on R1's condition, changes, medications, involve in care conferences, follow directions from hospice, and follow hospice standing orders. There was no hospice focus care planned intervention included in the facility care plan at admission of hospice 3/19/25. R1's hospital discharge summary dated 3/18/25, received by the facility 3/19/25 indicated R1 was discharged with hospice services. R1 was discharged with comfort medications hydromorphone (narcotic pain medication) and Lorazepam (anti-anxiety medication). R1 had the following wounds per the hospital summary: -Wound first assessed on 3/17/25 on his coccyx (tailbone) the wound was identified as moist and blanchable (skin discoloration that disappears when pressed upon and returns when pressure is released indicating the blood vessels in the areas are occluded therefore blood flow is obstructed), the peri wound (area surrounding the wound) was	F 849	if a resident is assessed to have an ineffective pain management regimen, on the facility designated hospice representative, Erin King-McCray, social services director, as well as the names and contact information of hospice personnel for 24/7 contact, and where to locate that information. The DON or designee will complete audits of 2 hospice residents weekly x 4 weeks, then monthly x 2 months and then review at QAPI to adjust frequency as indicated by audit data. Audits will include reviews to ensure hospice contact information is updated in residents' chart, plan of care is current, and medication regimen is effective. Audit results will be reviewed by the QAPI Committee for further recommendations.¿¿¿	

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F 849	Continued From page 55	F 849		

excoriated, red and moist. Mepilex dressing was used to cover the wound following cleansing.

-Suspected pressure ulcer to R1's left heel first assessed 3/17/25 the wound was purple, red, and fragile, the peri wound area was intact and red. The wound was cleansed and a Mepilex dressing applied.

-Suspected pressure ulcer to R1's right heel first assessed 3/17/25 the wound was red and intact, cleansed and covered with a Mepilex dressing.

-Suspected pressure ulcer to the left anterior foot first assessed 3/17/25 the wound was fragile, red, and intact, cleansed and covered with a Mepilex dressing.

-Wound to the right lateral foot first assessed 3/18/25 the wound was fragile, red, pink with black eschar (scabbing) painful, cleansed and covered with Mepilex.

-Wound to the right anterior knee first assessed 3/17/25 the wound was fragile and tan, cleansed and covered with a dressing.

R1's hospice plan of care dated 3/19/25, indicated R1's terminal diagnosis was acute hypoxic respiratory failure. Wound care order: Sacral wound and bilateral lower extremity wounds: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound skin. Cover with a foam bandage three times a week and as needed. Wound care was to be performed by the facility staff. R1's pain was to be managed and reported. If not controlled at 0-3 of 10 pain scale.

R1's facility nursing readmit data collection dated

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F 849	Continued From page 56 3/19/25, indicated under additional evaluation no pain was identified for R1. R1's skin condition indicated the coccyx, in the description, wound to right buttock cover with foam dressing. R1's significant change MDS dated 3/26/25 did not indicate a BIMs score. R1 was dependent on staff assistance with toileting, showering, dressing, personal hygiene, rolling in bed, bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were chronic congestive heart failure, opioid dependent, pain and chronic obstructive pulmonary disease. R1 had occasional pain with an intensity of an 8 (rated the worse pain over the last five days of the assessment on a zero to ten scale with zero being no pain and ten being the most pain imaginable. No further pain assessment was conducted per the MDS. R1 was identified on the MDS as being at risk of pressure ulcers, but had no pressure ulcers, nor was the MDS coded as having any other ulcers, wounds, or skin problems. Upon observation and interview on 4/28/25 at 3:39 p.m., R1 was lying on his back in a hospital bed wearing a hospital gown telling a friend about his back pain. R1 had dried blood on all five toes of his right foot. The second toe of his right foot had a dirty bandage on it. R1 agreed to a skin inspection, but stated he was in so much pain and it caused severe pain to move him. He requested the assistance of three staff members and requested they move him slowly. R1's sheet was pulled back and pressure ulcers were observed on both heels, and a pressure ulcer on his right lateral foot. Staff attempted to roll R1 onto his left side. R1 screamed in pain and gripped the side rail. He was screaming for staff	F 849		

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F 849	Continued From page 57 to stop. He was laid back on this back. R1's coccyx area appeared red, it was difficult to visualize and make an assessment as R1's pain level was so great the staff had to reposition him back on his back within seconds. At 3:58 LPN-B gave R1 a pain medication. At 5:00 p.m. R1 continued to state his pain was a 10/10 and staff was still unable to move him. R1 was not offered any addition management for his pain. The director of nursing (DON) was notified, and the staff began to assess R1's skin. Upon interview on 4/28/25 at 4:12 p.m. licensed practical nurse, LPN-B stated she was unable to complete R1's readmission skin assessment because she was unable to reposition him to view, his back. Since his readmission on 3/19, LPN-B stated staff had difficulty completing cares on R1 because touching him made him scream in pain. She stated she did not reach out to hospice as they were completing their own visits with him, and her job was to follow their orders which included giving as needed pain medications. She stated she had placed a foam dressing over R1's coccyx "from time to time", however did not chart placing the dressing because there were no orders for a dressing change and the wound was "small." She did not recall the last time she placed a dressing on his coccyx. LPN-B believed the wound care team or hospice was tending to R1's skin. Upon interview on 4/29/25 at 8:55 a.m. nursing assistant (NA)-A stated she completed incontinence cares on R1. He only allowed her to reposition him when he had a bowel movement requiring assistance with cleaning, because the repositioning was so painful for him. NA-A had seen an open wound on R1's coccyx and had	F 849		

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F 849	Continued From page 58 seen a dressing covering the area at times. She stated at times the dressing would be dirty and she would mention it to the nursing staff (unidentified staff and dates) and would be told the facility is not responsible for R1's skin. Upon interview on 4/29/25 at 10:04 a.m., hospice registered nurse, RN-B stated state she was aware that R1 had a coccyx wound and was not certain whether the facility had orders to tend to the wound or not. She was not aware of any heel or foot wounds. She stated she was completing the unscheduled visit on 4/29/25, because the family had reached out to hospice regarding R1's pain on 4/25/25. Hospice RN-B made changes to R1's pain regimen. Upon interview on 4/29/25 at 11:14 a.m. family member (FM)-A stated she received a call from the facility on 4/28/25 that R1 had some "sores" and hospice should have been taking care of them and the facility found out hospice was not. FM-A was not told the location or severity of the wounds. She stated she wondered if that was why R1 had so much pain. R1 had been calling her almost daily crying and when FM-A mentioned his pain to the facility, she was told they were giving him everything they could. She stated on 4/25/25 he called her sobbing on the phone wanting to go to the hospital due to his pain. FM-A notified Hospice. In addition, FM-A stated she had not seen staff reposition R1. R1 was laying in the same position on his back every time she visited him, and he had only attempted to get out of bed once since his hospital discharge of 3/19/25. Upon interview on 4/29/25 at 11:57 a.m., licensed practical nurse, LPN-A, nurse manager, stated	F 849		

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F 849	Continued From page 59 she was not aware until the survey observation findings that R1 had any pressure ulcers. She stated she reviewed the hospice notes and stated hospice was responsible for R1's ADL's (activities of daily living) so if there were any wound care treatments they would be performing them. She denied communicating with the hospice nurses regarding R1's pressure ulcers. In addition, LPN-A stated, staff should have reported uncontrolled pain to hospice and to her. She stated staff are to follow-up if pain had not resolved after they administered a pain medication. She was not certain if R1's pain regimen was effective. She stated hospice was responsible for his pain control. LPN-A denied reaching out to hospice regarding R1's pain. Upon interview on 4/29/25 at 4:37 p.m., hospice registered nurse, RN-B stated hospice does not complete wound care. He stated the orders were clear in R1's admission plan of care. He denied communication with the facility about R1's skin as he assumed since the facility did not reach out to him there were no concerns. He denied the facility reached out to him with regarding R1's pain control. Upon interview on 4/30/25 at 11:30 a.m. the facility's Medical Director stated he had not had any conversations with the hospice agency the facility uses since there had not been any concerns brought to his attention. Upon interview on 4/30/25 at 2:14 p.m. the assistant director of nursing ADON stated he is the certified wound specialist for the facility. R1's skin condition was brought to his attention on 4/29/25 at around 5:00 p.m. He stated he was able to assess R1's lower extremity wounds, but	F 849		

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F 849	Continued From page 60 the facility could not manage R1's pain to assess his coccyx wound until the morning of 4/30/25. He ordered treatments for the wound and reported the wounds to hospice. The ADON told hospice he wanted an as needed order so the facility could also change the dressing if they needed to, as he believed hospice was treating the wounds. The ADON stated LPN-A told him as he was assessing R1's wounds and that hospice was handling R1's wound treatments because they were doing his activities of daily living (ADL's). (see tag F686 for wound assessments). Upon interview and record review on 5/1/25 at 9:46 a.m., the DON stated the nurse who completed R1's assessment did miss the wounds, however the wounds were the responsibility of hospice, so the facility would not "necessarily" have documented the wounds. The DON reviewed R1's hospice care plan indicating the facility was to be completing wound care. His response was he had never seen the care plan from hospice before and would need to investigate it. Regarding R1's pain, the DON stated hospice oversaw him since his re-admission on 3/19/25. The DON stated there was a "fine line" for what pain medications would be covered by insurance, so the facility had to use what was provided for R1. R1 was a former opioid addict, therefore no matter how much medication the facility gave him he would ask for more. Upon interview and record review on 5/1/25 at 11:30 a.m. the Administrator stated the facility, and hospice should communicate to discuss the hospice resident, and the facility should document the communication. She would expect the facility to note and assess all wounds on their	F 849		

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F 849	Continued From page 61 residents no matter who was completing the wound care. If during a facility assessment, a wound was covered, she would expect the staff to remove the dressing if it were removable and assess the wound. If a resident were in so much pain that cares could not be performed, she would expect staff to reach out to the provider, hospice, or the regular provider if hospice were not involved. She reviewed the hospice care plan that indicated the facility should be providing wound care and stated she would look into the concerns. Upon interview on 5/1/25 at 10:30 a.m. hospice supervisor, RN-F stated since R1 resided in a skilled facility hospice and the facility work concurrently, meaning the standard is they work together. Hospice took the lead on providing treatment recommendations and orders. The facility was responsible for the day-to-day care for the residents since hospice only had one skilled nursing visit per week. She stated during R1's hospice period the facility called hospice on 4/3/25 with a question about R1's hospital bed. Per hospice charting on 4/8/25 hospice RN-B documented R1 had multiple pressure ulcers, and the facility was completing dressing changes. On 4/15/25 during a hospice visit hospice nurse RN-B asked facility nurse RN-C about R1's pain and RN-C told him R1 asked for pain medications frequently. On 4/25/25 R1's daughter called hospice and complained of R1 calling her crying in pain. On 4/28/25 hospice RN-E visited R1 and increased his pain medications. The immediate jeopardy was removed on 5/2/25, when it was verified, the facility implemented the following action:	F 849		

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F 849	Continued From page 62 On 5/2/25 The facility designated a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff to do the following: They appointed the Director of Social Services and educated her on the new responsibilities. On 5/2/25 the facility coordinated hospice care planning process for 6 residents receiving hospice services. The facility obtained the following information from the hospice: -The most recent hospice plan of care specific to each patient. -Names and contact information for hospice personnel involved in hospice care of each patient. On 5/25/25 the facility provided education on how to and when to access the hospice's 24-hour on-call system through the hospice residents banner on their face sheets and in their hospice hard copy chart. On 5/2/25 the facility identified hospice medication information specific to each patient including ineffective medication regimen, i.e., uncontrolled pain. each hospice resident was reviewed, and staff educated on monitoring effectiveness of pain medication and to reach out to the provider when the pain levels were uncontrollable. On 5/2/25 the facility providing hospice care under a written agreement ensured: Each resident's written plan of care included both the most recent hospice plan of care, and a	F 849		

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F 849	Continued From page 63 description of the services furnished by the LTC facility. Care plans were updated implementing the hospice care plans into the facility's care plans. The Nursing Facility Service Agreement dated 3/8/2018 indicated a facility policy titled Hospice dated 11/2023 indicated contracted hospice providers must have a written agreement with the facility outline (in detail) the responsibilities or the facility and the hospice agency. Are held responsible for meeting the same professional standards and timeliness of service as any contract individual or agency associated with the facility. It is the responsibility of the facility staff to notify the hospice provider and primary care provider about a significant change in the resident's condition or situations requiring a revision of the plan of care. The hospice agency will provide the facility staff with a copy of the hospice plan and a schedule of visits. Hospice staff will communicate and coordinate care with the interdisciplinary team (IDT). Facility Services. At the request of an authorized hospice staff member, facility shall admit Hospice Patients to Facility, subject to Facility's admission policies and procedures and the availability of beds. Facility shall immediately notify Hospice if Facility is unable to admit a Hospice Patient. Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed, and protected from negligent and intentional harm including. but not limited to, accident, injury, and infection. Facility's primary responsibility is to provide Facility Services. It is Facility's responsibility to provide Facility Services that meet the personal care and nursing needs that would have been provided by a Hospice Patient's primary caregiver	F 849		

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F 849	Continued From page 64 at home, and Facility shall perform Facility Services at the same level of care provided to each Hospice Patient before hospice care was elected. While Facility's nursing personnel may, as specified by Facility, assist in administering prescribed therapies to Hospice Patients under the Plan of Care, such assistance may only be provided to the extent the activity is permitted by law and only to the extent that Hospice would routinely utilize the services of a Hospice Patient's family in implementing the Plan of Care. Availably- Facility shall be available to provide Facility Services 24 hours per day, 7 days per week and shall maintain sufficient personnel who have the requisite training, skills, and experience to meet this obligation. Notification of Services - Facility shall fully inform Hospice Patients of Facility Services, Other Facility Services and Uncovered Items and Services to be provided by Facility. [NOTE: It is important for the hospice to ensure that the patient is fully aware of who is responsible for services and who will pay for services that are not related to the patient's terminal illness.] Coordination of Care. a. General - Facility shall participate in any meetings, when requested, for the coordination. supervision and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each Hospice. Patient Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day. b. Resident of Plan of Care. In accordance with applicable federal and state laws and regulations,	F 849		

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F 849	Continued From page 65 Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for development of the Plan of Care. c. Modifications to Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will! not make any modifications to the Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate level of hospice care provided to each Hospice Patient d. Notification of change in condition - Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient Facility\ Representative: Facility shall designate a member of Facility's interdisciplinary team who is responsible for working with Hospice to coordinate care provided by Facility staff and Hospice staff to any Hospice Patient under Hospice's care. Such interdisciplinary team member shall be responsible for the following: (i) collaborating with Hospice and coordinating Facility staff participating in the hospice care planning process for those Hospice Patients who are under Hospice's care; (ii) communicating with Hospice end other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the Hospice Patient and family; {iii) ensuring that Facility communicates with the Hospice medical director, the Hospice Patient's attending physician, and other practitioners participating in	F 849		

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F 849	Continued From page 66 the provision of care to the Hospice Patient as needed to coordinate the hospice care with the medical care provided by other physicians; (iv) obtaining the following information from Hospice: (A) The most recent Hospice Plan of Care specific to each Hospice Patient; (B) Hospice election form; (C) Physician certification and recertification of the terminal illness specific to each Hospice Patient; (D) Names and contact information for Hospice personnel involved in hospice care of each Hospice Patient; (E) Instructions on how to access the Hospice's 24-hour on-call system; (F) Hospice medication information specific to each Hospice Patient; (0) Hospice physician end attending physician (if any) orders specific to each Hospice Patient; (v) ensuring that the Facility provides to Hospice an orientation with respect to the policies and procedures of the facility, including Hospice Patient rights. appropriate forms, and record keeping requirements. Facility shall notify Hospice promptly of any change in the designated interdisciplinary team member.The Facility care must ensure that each Hospice Patient's written plan of care includes both the most recent hospice plan of care if applicable, and a description of the services furnished by. Facility to attain or maintain the Hospice Patient's highest practicable physical, mental, and psychosocial well-being as required. Facility shall monitor the delivery of Facility Services to the Hospice Patients to assure the services provided meet the assessed needs of each Hospice Patient.	F 849		

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F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to conduct regular inspections of bed frames, mattress, and bed rails as part of the regular maintenance program to identify areas for entrapment for 2 of 2 residents (R1, R2) reviewed for bed rails. Findings include: Food and Drug Administration (FDA) guidelines "Recommendations for Health Care Providers about Bed Rails" 2018 indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bedrails, mattresses, and bed frames are interchangeable; check the manufacture instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical	F 909	R1 passed away on 05/01/2025. R2's bed was inspected and bedrails tightened. Full-house audit conducted on resident bed frames, mattresses, and bedrails, to identify risk for entrapment. Residents' beds and bedrails are inspected monthly by maintenance through the TELS Work Order system. All residents have the potential to be affected by this deficient practice. Education provided to staff regarding bed frames, mattresses, and bedrails, to identify risk for entrapment. Maintenance or designee to complete random audits of resident bed frames, mattresses, and bedrails, to ensure the resident is not at risk for entrapment weekly times 4 weeks. Audit results to be brought to QAPI for further review and recommendation.	5/28/25

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F 909	Continued From page 68 restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails select the appropriate bed rail, follow the health care providers procedures or manufacture recommendations, inspect, evaluate, and regularly check bedrails are appropriately matched to equipment and patient needs considering all relevant risk factors, to identify and remove potential fall and entrapment hazards. Be aware that gaps can be created by movement or compression of the mattress, which may be caused by patient weight, movement, bed position, or by using a specialty mattress. Retrieved from https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/BedRailSafety/ucm362848.htm Food and Drug Administration (FDA) guidelines "Recommendations for Health Care Providers Using Adult Portable Bed Rails" 2023 indicated be aware that not all bed rails, mattresses, and bed frames are interchangeable and not all bed rails fit all beds. Check with the manufacturers to make sure the bed rails, mattress, and bed frame are compatible. Use caution when using bed rails with a soft mattress as this may increase risk of entrapment between the mattress and bed rail. Be aware that gaps can be created by movement or compression of the mattress which may be caused by patient weight, patient movement, or bed position, or by using a specialty mattress, such as an air mattress, mattress pad or waterbed. Retrieved from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails.	F 909		

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F 909	Continued From page 69 R1's quarterly Minimum Data Set dated 2/6/25 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 14 indicting R1 was cognitively intact. R1's significant change dated 3/26/25 did not indicate a BIMs score R1 was dependent on staff assistance with toileting, showering, dressing, personal hygiene, rolling in bed, bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were chronic congestive heart failure, opioid dependent, pain and chronic obstructive pulmonary disease. Bed rails were not identified as used on the MDS. Upon observation and interview on 4/28/25 at 12:35 p.m. R1 was resting in bed. R1 had an air mattress and bilateral halo bed rails (bed rails that have a circular shape with bars inside) at the head of his bed. R1 state he started on hospice about six weeks ago and received the hospital bed, the air mattress, and the bed rails. R1 stated he used the rails to help himself reposition while in bed and so he would not fall out of bed. He stated he would not be able to remove the rails from the bed on his own. R2's annual MDS dated 3/20/25 indicated R2's BIMs score was a 13 indicating R2 was cognitively intact. R2 required moderate assistance with toileting and rolling from left to right in bed. He required maximum assistance with dressing, bathing, and transferring. R2's pertinent diagnoses were hemiplegia following cerebral vascular disease (stroke followed by weakness or partial paralysis on one side of the body) and cardiomyopathy (heart disease of the muscle that affects its ability to pump blood). R2's	F 909		

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F 909	Continued From page 70 MDS did not indicate a bed rail was used. Upon observation and interview on 4/29/25 at 12:16 p.m. R2 was lying in bed he had bilateral quarter rails at the head of his bed. He stated he uses the rails to get out of bed to his chair. A facility document dated 4/29/25 by TELS indicated Beds and Mattresses: Inspection of beds and mattresses was completed on time by the director of maintenance. The steps of the inspect were to remove items in poor condition. Clean and care per manufactures recommendations on a regular schedule, sanitize all surfaces. The maintenance check included to inspect connectors on rails and tighten, as necessary. Remove any burs or rough edges to prevent injury. Verify the function of the spring latch-knob assembly, if applicable. Ensure the latch was free from dirt. Ensure the rails engage and lock as specified. Tighten, adjust, or replace any parts that were loose or who signs of missing parts. The document did not indicate how often the beds were to be inspected, identification of areas of entrapment, if the equipment used was compatible, or if the director of maintenance's check was a verbal check or a physical check. Email correspondence on 4/30/25 at 1:57 p.m. the Administrator indicated the bed rail inspections were a non-documented task. The email included the TELs inspection report as indicated above. Upon interview on 4/29/25 at 11:57 a.m. licensed practical nurse, (LPN)-A, nursing manager was not certain if maintenance measured the zones of the bed rails. She stated the only maintenance involvement with rails she was aware of was	F 909		

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F 909	Continued From page 71 assembling some of the facilities beds and called upon if a device required repairs. Upon interview on 4/29/25 at 2:14 p.m. the assistant director of nursing (ADON) stated he was not certain how maintenance conducted bed safety checks. Upon interview on 4/30/25 at 1:44 p.m. the director of maintenance stated he was not aware that R1 had a halo rail along with an air mattress. He did not assemble R1's hospital bed nor had he checked on it. He stated he checks beds when staff puts a message into TELS (building services messaging system for updates and repair notifications), or he is prompted to complete a facility check per TELS. He stated he does a verbal assessment monthly and a physical check on the bed rails quarterly. He confirmed he did not measure the bed rails for zone safety upon implementation of the rails. He had worked at the facility for three months and stated he had not completed a physical check for the residents who had electric beds and/or bed rails. He stated his department had been short staffed therefor he had not been able to complete the physical inspections yet. He believed he was to complete a verbal inspection monthly which meant he would ask nursing staff if there were any concerns with any of the beds or rails. Quarterly he would complete a physical maintenance check to make sure all bedrails were right and clean. He did not individually document the verbal inspect he completed on 4/29/25 (completed during survey). He stated the TELS system pulls up a list of all the residents and the bed and rails they have. Once completed he placed a check mark in the box indicating everything was completed on all the identified residents. He was not certain if	F 909		

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F 909	Continued From page 72 he or who was to verify the compatibility of the bed with the devices, especially the ones that came in from hospice. Most of the beds and rails the facility used were standard and had all the same components therefore they would not have required a compatibility check. Upon interview on 5/5/25 at 2:33 p.m. the Administrator stated as per her email the maintenance director completes the inspections through TELS monthly and his documentation is checking the box when completed. He did not check off on each resident. Upon interview on 5/5/25 at 2:40 p.m. the director of nursing, DON stated the maintenance department inspects all the beds in the facility monthly. He was not certain of all inspection criteria or how it is was logged. The pressure mattress (air mattress) manufacturer's instruction manual undated indicated: Due to concerns over the possibility of patient entrapment, the use of rails of any length is a matter currently addressed by federal and state laws/guidelines, and by individual facility protocol. It is the responsibility of the facility to be in compliance with these laws, which typically require that decisions on the use of bed rails of any type are based on assessment of the physical and mental status of each patient individually. If the patient needs bedrails to prevent fall-related injury, as determined by this facility assessment, we recommend that the bedrails be always locked in the up position. We do not require use of bedrails unless the patient is deemed to be safer with them than without them. The halo rails manufacturer instructions indicated	F 909		

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F 909	Continued From page 73 undated indicated: Mattress must remain in firm contact with the Halo Safety Ring on both sides of the bed. If a Halo Safety Ring is only installed on one side of the bed, the mattress must remain in firm contact with the mattress stay or mount bracket on the other side of the bed. Proper patient assessment and monitoring, and proper maintenance and use of equipment is required to reduce the risk of entrapment. Variations in mattress thickness, size or density could increase the risk of entrapment. Visit the FDA website at http://www.fda.gov to learn about the risks of entrapment. Regularly check the Halo device to identify areas of possible entrapment, immediately cease using the bed until entrapment risk is fixed. Regularly check to make sure that there is no gap between the Halo Safety Ring and the side of the mattress. A gap could allow the user to become wedged between the bed rail and the mattress. Follow all assembly instructions carefully. Failure to follow the instructions could result in serious injury to the user(s) of the product. The quarter bed rail manufacturer guide undated indicated: indicated a routine inspection was to include Risk of serious injury or death. Use a properly sized mattress to minimize the gap between the side of the mattress and the assist rail. This gap must be small enough to prevent a resident from getting their head or neck caught in this location. Make sure raising or lowering the bed, or articulating the sleep surface, does not create hazardous gaps. Failure to do so could result in serious injury or death. This assist rail is only one part of your healthcare bed system. Proper combinations of bed, mattress, head/foot panels and assist rails are needed to minimize the risk of entrapment. For more information,	F 909		

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F 909	Continued From page 74 contact your representative. A facility policy titled Safe Medical Device dated 3/2009 indicated the definition of a medical device, malfunctioning of the device, a reportable evident and serious injury. The policy did not indicate the inspection or maintenance of the devices.	F 909		

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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 4/28/25 - 5/5/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 05/22/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H52953591/MN00112561 with a licensing order issued at ST0900.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a comprehensive skin assessment identifying pressure ulcers, treatments, and monitoring, resulting in serious harm, for 1 of 3 residents (R1) reviewed for pressure ulcers. R1 returned from a hospital admission and the hospital discharge summary indicated upon admission to the hospital, R1 had pressure ulcers to his coccyx, left heel, right heel, lateral right foot. The	2 900	Corrected.	5/5/25

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2 900	Continued From page 2 treatment for all the wounds was to cleanse and change the dressing. This resulted in an Immediate Jeopardy for R1 when the facility failed to provide the necessary treatment to R1 upon his return from the hospital for approximately six weeks. The immediate jeopardy began on 3/19/25, when R1 returned from a hospital admission with pressure ulcers. These pressure ulcers were not treated for approximately six weeks. The administrator, director of nursing, and regional nurse manager were notified of the immediate jeopardy at 5:10 p.m. on 5/1/25. The immediate jeopardy was removed on 5/2/25, but noncompliance remained at the lower scope and severity level 2 D - isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: Upon observation and interview on 4/28/25 at 3:39 p.m. R1 was on his back in a hospital bed wearing a hospital gown telling a friend about his back pain. R1 agreed to a skin inspection, but stated he was in so much pain it caused severe pain to move him. He requested the assistance of three staff members and requested they move him slowly. R1 had dried blood on all five toes of his right foot. The second toe of his right foot had a dirty bandage on it. R1's sheet was pulled back and pressure ulcers were observed on both heels, and a pressure ulcer on his right lateral foot. Staff attempted to roll R1 onto his left side. R1 screamed in pain and gripped the side rail. He was screaming for staff to stop. He was laid back on this back. R1's coccyx area appeared red, it was difficult to visualize and make an	2 900		

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2 900	Continued From page 3 assessment as R1's pain level was so great the staff had to reposition him back on his back within seconds. At 3:58 LPN-B gave R1 a pain medication. At 5:00 p.m. R1 continued to state his pain was a 10/10 and staff was still unable to move him. R1 was not offered any addition management for his pain. The director of nursing (DON) was notified, and the staff began to assess R1's skin. According to the State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, revised 08-08-2024, indicated: -"Pressure Ulcer/Injury (PU/PI)" refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. Soft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue. - "Avoidable" means that the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors; define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate. -Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable	2 900		

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2 900	Continued From page 4 erythema (redness). In darker skin tones, the PI may appear with persistent red, blue, or purple hues. The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue PI (see below). -Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink, or red, moist, and may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. This stage should not be used to describe moisture associated skin damage including incontinence associated dermatitis, intertriginous dermatitis (inflammation of skin folds), medical adhesive related skin injury, or traumatic wounds (skin tears, burns, abrasions). R1's physician orders dated 2/24/25 - 4/27/25 indicated on 2/25/25 R1 was to have the skin around his nose and behind his ears checked due to any skin concerns due to his oxygen tubing. On 3/4/25 R1 was to have weekly skin inspections by nursing staff. On 4/8/25 R1 had wound care to cleanse wound to right ankle with wound cleanser, pat dry and apply foam gauze dressing daily and as needed. No other wound orders were documented. R1's nursing progress note dated 3/4/25 indicated the wound practitioner saw R1 on wound rounds for an abscess on buttocks. The abscess was improving. The abscess was located on the right gluteal fold (area where the leg meets the buttocks).	2 900		

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2 900	Continued From page 5 R1's nursing progress note dated 3/7/25 the interdisciplinary team (IDT) team met and reviewed the weekly wound rounds. R1's orders were up to date for the abscess to his right gluteus. R1's nursing progress note dated 3/14/25 a chest x-ray was ordered. R1 was alert and oriented. Vital signs within normal limits. Administered all medications to and wound care completed to coccyx/buttocks, no signs of infection. There were no measurements, assessment, or what type of treatment were completed to coccyx. The note failed to identify if this was a new area and/or if physician had been notified. R1's nursing progress notes dated 3/15/25 identified R1 was transferred to the hospital due to acute confusion, jitteriness, and a blood pressure of 70/40 (normal 120/80). R1 had ongoing wounds on his buttocks. The note failed to identify what types of wounds, any measurement or description. R1's hospital discharge summary dated 3/18/25 received by the facility on 3/19/25 indicated: -Wound first assessed on 3/17/25 on his coccyx (tailbone) the wound was identified as moist blanchable (skin discoloration that disappears pressed upon and return when pressure is released indicating the blood vessels in the areas are occluded therefore blood flow is obstructed), the peri wound (area surrounding the wound) was excoriated, red and moist. Mepilex dressing was used to cover the wound following cleansing. -Suspected pressure ulcer to R1's left heel first assessed 3/17/25 the wound was purple, red, and fragile, the peri wound area was intact and red. The wound was cleansed and a Mepilex dressing applied.	2 900		

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2 900	Continued From page 6 -Suspected pressure ulcer to R1's right heel first assessed 3/17/25 the wound was red and intact, cleansed and covered with a Mepilex dressing. -Suspected pressure ulcer to the left anterior foot first assessed 3/17/25 the wound was fragile, red, and intact, cleansed and covered with a Mepilex dressing. -Wound to the right lateral foot first assessed 3/18/25 the wound was fragile, red, pink with black eschar (scabbing) painful, cleansed and covered with Mepilex. -Wound to the right anterior knee first assessed 3/17/25 the wound was fragile and tan, cleansed and covered with a dressing. R1's hospital discharge summary dated 3/18/25, received by the facility 3/19/25 indicated R1 was discharged with hospice services. There was no documentation of skin integrity. R1's nursing progress note dated 3/19/25, indicated R1 returned from the hospital. R1 signed onto hospice. R1's hospice plan of care dated 3/19/25, indicated R1's terminal diagnosis was acute hypoxic respiratory failure. Wound care order: Sacral wound and bilateral lower extremity wounds: Cleanse with wound cleanser, pat dry, apply skin prep to peri wound skin. Cover with a foam bandage three times a week and as needed. Wound care was to be performed by the facility staff. R1's facility nursing readmit data collection dated 3/19/25, indicated under additional evaluation no pain was identified for R1. R1's skin condition indicated an area on the "coccyx." In the summary notes included, "wound to right buttock cover with foam dressing. Will continue to follow	2 900		

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2 900	Continued From page 7 wound nurse. No monitoring, assessing, or any type of treatment was added to the care plan or the Treatment Administration Record (TAR) for this area on the coccyx. R1's nursing progress note dated 3/20/25, indicated the IDT met to review the weekly wounds to the abscess of his right gluteus. Wound improving. The note did not identify any new wounds as identified in the hospital record. The progress note did not address the pressure ulcers on his coccyx, left heel, right heel, or lateral right foot. R1's nursing progress note dated 3/21/25, indicated R1 refused his weekly skin assessment. R1's significant change Minimum Data Set (MDS) dated 3/26/25 did not indicate a Brief Interview for Mental Status (BIMS) score, R1 was dependent on staff assistance with toileting, showering, dressing, personal hygiene, rolling in bed, bed to chair transferring. R1 was always incontinent of bowel and bladder. R1's pertinent diagnoses were chronic congestive heart failure, opioid dependent, pain and chronic obstructive pulmonary disease. The MDS included there were no pressure ulcers or any other skin conditions or wounds to the feet. There was no mention of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot as identified by the hospital on 3/17/25. R1's nursing progress note dated 3/27/25, indicated IDT weekly wound review indicated R1's abscess of the right gluteus had been resolved. There was no assessment of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot.	2 900		

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2 900	Continued From page 8 R1's electronic treatment administration records (eTAR) dated 4/1/25 - 4/27/25, indicated R1 was to have a weekly skin inspection. Wound cares to cleanse wound to right ankle with wound cleanser pat dry and apply foam gauze daily and as needed. Nurse to monitor and chart on resident picking at skin, scabs, wounds, if noted bleeding. If noted clean area and cover with bandage every day and evening shift. All treatments were marked as complete. The ulcer to his coccyx was not identified on the TAR. The pressure ulcers on R1's heels were not identified on the TAR either. No assessment of these areas was documented. R1's weekly skin inspection dated 4/4/25, indicated R1 had the same old wounds, no new skin issues noted. No actual assessment of any area of his skin was documented. R1's nursing progress note dated 4/7/25, indicated the facility nurse spoke with RN-B from hospice and asked if he would be writing orders for R1's wounds to his right foot/ankle and he stated he would. Writer asked for a treatment order and wanted R1 to be added to the facility wound rounds. Hospice RN-B stated he would be coming the following day or the next and would assess the leg and write treatment orders. The provider was updated, and nurse will clean and dress wounds daily. R1's facility care plan dated 4/9/24 - 4/28/25, did not indicate any skin integrity concerns for R1. R1's nursing progress note dated 4/11/25, indicated wound treatment to right foot was completed with assistance from a fellow nurse. There was no mention of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot or any assessment of the right foot.	2 900		

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2 900	Continued From page 9 R1's nursing progress note dated 4/17/25, indicated for nurses to please monitor and chart on R1 for picking at skin, scab's wounds. If noted bleeding if noted clean area and cover with bandage. There was no mention of pressure ulcers on his coccyx, left heel, right heel, or lateral right foot. R1's weekly skin inspection dated 4/18/25, indicated R1 had no new skin issues. Ongoing wound care to his right foot. There was no assessment of any skin ulcers or skin conditions documented. R1's nursing progress note dated 4/23/25, indicated for nurses to please monitor and chart on R1 for picking at skin, scab's wounds. If noted to be bleeding, clean area and cover with bandage. The following skin and wound evaluations and orders were completed during the survey process: -R1's skin and wound evaluation on 4/28/25 at 4:51 p.m., indicated R1 had a pressure ulcer (deep tissue injury) on his right medial malleolus (inside of the ankle) in-house acquired with an area 1.5 centimeters squared (cm), length 1.9 cm, width 1.1 cm. There was no documentation of the wound bed. -R1's Skin and wound evaluation on 4/28/25 at 4:56 p.m., indicated R1 had an unstageable (obscured full-skin and thickness skin and tissue loss) pressure ulcer on his right lateral (outside) foot in-house acquired. The wound area measured 4.3 cm, length 3.1 cm, width 1.8 cm, 0 depth, 60 % granulated (healing tissue in a	2 900		

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2 900	Continued From page 10 wound bed), 40% slough (dead tissue and debris in a wound bed), light exudate (fluid in the wound, part of the healing process). -R1's skin and wound evaluation on 4/29/25 at 7:24 a.m., indicated R1 had unstageable pressure ulcer on his sacrum in-house acquired with an area of 32.9 cm, length 5.4 cm and with 7.8 cm, 0 depth. The wound was 50% granulated and 20% slough and 30% eschar (scab, dead cells). The wound had moderate serosanguineous exudate (mixture a watery bodily fluid and blood). -R1's weekly skin inspection summary dated 4/29/25 at 7:57 a.m., indicated R1 had a pressure ulcer on his sacrum, left and right buttocks. Pressure wound on his right lateral malleolus. Pressure wound on his right lateral foot. Pressure wound on his right medial malleolus. Abrasion of his left dorsum (top) 5th toe. Abrasion of his right dorsum 2nd toe. Abrasion of his right dorsum 1st toe. The wounds were assessed by the in-house wound nurse and treatment completed. Hospice and medical provider updated, and treatment orders obtained. -R1's clinical physician orders dated 4/29/25, indicated R1 was to have wound care to his sacrum (left and right buttock) cleanse wound with wound cleanser pat dry, apply skin prep to peri-skin. Apply calcium alginate to wound bed and cover with foam. -R1's clinical physician orders dated 4/30/25, indicated R1 was to have wound care to his right later malleolus and right lateral foot. Cleanse wound with wound cleanser, pat dry, apply skin prep to peri-skin. Apply Calcium Alginate to wound bed and cover with foam dressing.	2 900		

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2 900	Continued From page 11 -R1's clinical physician orders dated 4/30/25, indicated R1 was to have wound care to his right medical malleolus. Apply skin prep to discolored area. -R1's clinical physician orders dated 4/30/25, indicated wound care to left 5th toe, right 2nd toe and right 1st toe. Apply skin prep to scabbed areas and cover with bandage. Upon interview on 4/28/25 at 4:12 p.m., licensed practical nurse, LPN-B stated she was unable to complete R1's readmission skin assessment because she was unable to reposition him to view his back. Since his readmission on 3/19/25 staff had difficulty completing cares on R1 because "touching him made him scream in pain." She did not reach out to hospice as they were completing their own visits with him. She had placed a foam dressing over R1's coccyx at some point. She did not chart placing the dressing because there were no orders for a dressing change and the wound was "small." She did not recall the last time she placed a dressing on his coccyx. LPN-B believed the wound care team or hospice was treating R1's skin. Upon interview on 4/29/25 at 8:55 a.m., nursing assistant (NA)-A stated she completed incontinence cares on R1, R1 would only let her reposition him when he needed cleaning following a bowel movement due to his pain. NA-A saw an open wound on R1's coccyx and at times the area had a dressing covering the area. She stated the dressing would be dirty and she would tell the nursing staff (unidentified staff and dates) and would be told the facility is not responsible for R1's skin.	2 900		

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2 900	Continued From page 12 Upon interview on 4/29/25 at 10:04 a.m. hospice registered nurse, RN-B stated she was aware that R1 had a coccyx wound. She was not certain whether the facility had orders to tend to the wound or not. She was not aware of any heel or foot wounds. Upon interview on 4/29/25 at 11:14 a.m., family member (FM)-A stated she received a call from the facility on 4/28/25 that R1 had some "sores" and hospice should have been taking care of them, but the facility found out they were not. FM-A was not told the location or severity of the wounds. She stated she wondered if that was why R1 had so much pain. R1 had been calling her almost daily crying in pain. FM-A mentioned his pain to the facility, she was told they were giving him everything they could. She stated on 4/25/25, R1 called her sobbing on the phone wanting to go to the hospital due to his pain. FM-A notified Hospice. FM-A stated she had not seen staff reposition R1. Every time she visited him, he had was laying in the same position, on his back, and he had only attempted to get out of bed once since his hospital discharge of 3/19/25. Upon interview on 4/29/25 at 11:49 a.m. RN-A stated during her weekly skin assessment she did not notice any pressure ulcers on R1, however repositioning him due to his pain made it difficult to visualize his skin. She stated she would not be measuring his wounds during an assessment as the facility has a wound team that takes care of all the measurements. She was unable to perform a full body assessment at any point due to pain. She did not notify hospice or the provider about this. Upon interview on 4/29/25 at 11:57 a.m. licensed practical nurse, (LPN)-A nurse manager stated	2 900		

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2 900	Continued From page 13 she was not aware until the survey observation findings that R1 had any pressure ulcers. She stated she reviewed the hospice notes and stated hospice was responsible for R1's ADL's (activities of daily living) so if there were any wound care treatments they would be performing it. She did not communicate with the hospice nurses regarding R1's pressure ulcers. LPN-A did not know hospice was only providing care once a week and did not see the orders that R1 had pressure ulcers. Upon interview on 4/29/25 at 4:37 p.m., hospice registered nurse, RN-A stated hospice does not complete wound care. He stated the orders were clear in R1's admission plan of care. That the facility was to complete the wound treatment. RN-A did not communicate with the facility about R1's skin because the hospice plan of care indicated the facility was completing R1's wound treatments. He assumed since the facility did not reach out to him there were no concerns with R1's skin. Upon interview on 4/30/25 at 11:30 a.m., the facilities Medical Director stated the facility is the main provider of care to the residents and must know who is providing any treatments. Upon interview on 4/30/25 at 2:14 p.m. the assistant director of nursing ADON stated he was the certified wound specialist for the facility. R1's skin condition was brought to his attention on 4/29/25 at around 4:45 p.m. He was able to assess R1's lower extremity wounds, but the facility could not manage R1's pain enough to assess his coccyx wound until the morning of 4/30/25. He ordered treatments for the wounds and reported the wounds to hospice. He stated he ordered daily dressing changes and hospice	2 900		

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2 900	Continued From page 14 changed the orders to three times a week, Monday, Wednesday, and Friday. The ADON told hospice he wanted as needed order so the facility could also change the dressing, believing hospice was completing R1's treatments. He stated LPN-A told him upon his wound assessment that hospice was handling R1's wounds because they were doing his activities of daily living (ADL's). R1's progress note dated 5/1/25 at 7:02 a.m. indicated R1 had passed away. An undated note found in R1's handwriting in his notebook found after his passing undated indicated "Thursday morning 7 a.m. convinced nurse to take bandage off lower back burning pain in lower back, bandage not looked at or attended for over 1 month." Upon interview and record review on 5/1/25 at 9:46 a.m. the director of nursing (DON) stated the nurse who completed R1's assessment did miss the wounds, however the wounds were the responsibility of hospice, so the facility would not "necessarily" have documented the wounds. The DON reviewed R1's hospice care plan indicating the facility was to be completing wound care and stated he never saw the hospice plan of care before and would need to investigate it. Upon interview and record review on 5/1/25 at 11:30 a.m., the Administrator stated the facility, and hospice provider should communicate to discuss the hospice resident, and the facility should document the communication. She would expect the facility to note and assess all wounds on their residents no matter who was completing the wound care. If during a facility assessment a wound was covered, she would expect the staff to remove the dressing if it were removable and	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: _____ B. WING _____	C 05/05/2025

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2 900	Continued From page 15 assess the wound. The Administrator was not certain who was providing wound care for R1. The immediate jeopardy was removed on 5/2/25, when it was verified, the facility completed the following actions, on 5/2/25 The facility identified other residents at risk for pressure ulcers, reviewed policy, and procedures, and educated staff on the following: -Completion of comprehensive skin assessments according to professional standards. -Developed care planned treatments and monitoring to accurately reflect resident needs. A facility policy titled Skin Assessment and Wound Management with a revised 2/2025 indicated Provide guidelines for assessing and managing wounds were: A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change. Staff will perform routine skin inspections (with daily care). Nurses are to be notified if skin changes are identified. Licensed staff will complete a weekly skin inspection. 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: Notify Provider/Treatment Ordered. Notify resident representative. Complete education with resident/resident representative including risks & benefits. Initiate Skin and Wound Evaluation.	2 900		

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2 900	Continued From page 16 Notify Nurse Manager/Wound Nurse. Referral to dietary, if appropriate. Referral to therapies, if appropriate. Review and update care plan including interventions. Update resident care lists. Update Care Plan to identify risks for skin breakdown. When a pressure ulcer is identified, the following actions will be taken: Notify Provider/Treatment Ordered. Notify resident representative. Complete education with resident/resident representative including risks & benefits. Initiate Skin and Wound Evaluation. Notify Nurse Manager/Wound Nurse. Referral to dietary, if appropriate. Referral to therapies, appropriate. Review and update care plan including interventions. Update resident care lists. Update Care Plan to identify risks for skin breakdown. Follow ongoing treatments per provider order. Update provider and resident/representative as needed. Update care plan as needed. 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		