Electronically delivered

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

RE: CCN: 245337
Cycle Start Date: December 22, 2020

Dear Administrator:

On December 22, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 22, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 22, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	245337	A. BUILDING _____ B. WING _____	C 12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LINDEN LLC	**105 WEST LINDEN STREET STILLWATER, MN 55082**

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F 000	INITIAL COMMENTS On December 21, & 22, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5337044C/MN00068225, with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		1/14/21

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

Electronically Signed | 01/14/2021

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F 686	Continued From page 1 Based on observation, interview and document review, the facility failed to monitor, re-evaluate, modify interventions/treatment and notify the physician of a worsening pressure ulcer for 1 of 2 residents (R1) who developed a stage III pressure ulcer (Full thickness skin loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) at the facility. The failure resulted in actual harm for R1 who required hospitalization for sepsis related to an infected pressure ulcer and debridement (a procedure that involves thoroughly cleaning the wound and removing infected, and necrotic or dead tissue) reviewed for pressure ulcers. Findings include: R1's admission Minimum Data Set (MDS) dated 11/30/20, identified R1 had severe cognitive impairment and required extensive to total assistance for all activities of daily living including transfers, bed mobility, getting dressed, toilet use and eating. The MDS identified R1 was always incontinent of bladder and bowel. The MDS identified R1 did not have a pressure ulcer, but had a surgical wound, was at risk to develop pressure ulcers, did not reject cares but had physical behavioral symptoms towards others including hitting. Pressure reducing devices had been applied for the chair and the bed. Further, the MDS identified R1 diagnoses included dementia and fracture of unspecified part of neck of left femur. R1's pressure ulcer/injury Care Area Assessment dated 12/7/20, identified R1 was at risk for skin breakdown due to but not limited to: recent	F 686	R1 has had the following completed: • Reassessment of skin • Weekly wound/skin evaluation • Provider and responsible party has been updated on wound status. • Care plan reviewed and updated. • Nursing assistant sheets updated to reflect current interventions. All residents at risk for skin breakdown may be affected. Skin audits completed for residents and care plans updated as needed. The following has been completed to prevent recurrence skin assessment and wound policy reviewed Education for licensed staff conducted on the following as it pertains to skin: • Skin assessment • Weekly skin inspection • Management of new pressure ulcers • Pressure ulcer risk and interventions for pressure ulcer prevention. • Communication/ notification of provider and responsible party Education for non- licensed nursing staff conducted on the following as it pertains to pressure ulcers: • Causes of pressure ulcers • Repositioning • Toileting • Reporting skin observations Weekly audits, developed with wound/skin policy, will be done on residents with a pressure ulcer and new admission /readmissions. Findings of the audits will be reported monthly to the QA/QAPI committee. The QA/QAPI committee will	

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F 686	Continued From page 2 admission to facility, incontinent of bowel et bladder, cognitive impairments, dependent on staff for all repositioning and bed mobility. The CAA directed staff to reposition R1 every two to three hours and as needed, to complete weekly skin assessments by nurse and the nurses were to update the physician with any signs and symptoms of skin breakdown R1's care plan dated 11/24/20, identified R1 admitted to the facility 11/24/20, had a deficit in self-care and mobility and directed staff to assist. The care plan did not identify R1 was at risk for pressure ulcers, however on the undated nursing assistant care sheet staff were directed to turn and reposition, R1 every two hours. R1's medical record was reviewed and included the following entries related to skin: -Braden Scale Score Risks (a tool used to predict pressure ulcer risk), conducted on 11/25/20, 12/2/20 and 12/9/20, all identified a score of 18 (15-18: mild risk for breakdown). -MHM Weekly Skin Inspection, "Admission" assessment, dated 11/29/20, identified no new skin issues noted. Documentation lacked information to identify what the skin had looked like to determine what, "no new issues" referenced. -Progress Note dated 12/3/20, indicated "Resident has a wound on his coccyx that writer found today, cleansed and dried and wound dressings applied." There was no indication an assessment of the PU had been completed, to identify PU stage, size, depth, drainage, odor or pain.	F 686	determine on going frequency and continuation of audits. DON/ designee will be responsible	

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F 686	Continued From page 3 -MHM Weekly Pressure Wound Evaluation, dated 12/4/20, identified R1 had a stage III wound in the sacrum area which measured 3.0 centimeters (cm) by 3.5 cm by 1.0 cm. and the description of wound was it had an ample amount of slough (Non-viable yellow, tan, gray, green or brown tissues, usually moist, can be soft, stringy, and mucinous in texture) and eschar (Dead or devitalized tissue that is hard or soft in texture, usually black, brown, or tan in color and may appear like a scab). The interventions implemented included air mattress to be delivered and per the assessment. The physician was contacted and treatment orders to cleanse, skin prep peri wound, silver alginate and apply a large foam dressing. The evaluation also identified, referral to dietary, referral to therapies, notifying the nurse manager/wound nurse and initiate weekly pressure wound evaluation. -MHM Weekly Skin Inspection dated 12/6/20, identified R1 had wound around his coccyx, however no description of the status of the wound was noted on the assessment. -December treatment administration record (TAR) revealed an order with start date 12/5/20, directed staff to "Cleanse, skin prep periwound, silver Alginate, large foam dressing in the morning wound care." During further review of the TAR it was revealed from 12/5/20, through 12/10/20, R1's wound treatment had been signed off as completed however, the medical record lacked documentation of the status of the wound, whether drainage was present, status of the area surrounding the pressure ulcer, possible complications such as signs of increasing area or soft tissue infection and pain.	F 686		

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-MHM Weekly Pressure Wound Evaluation, dated 12/11/20, identified R1 had a wound in the coccyx which measured 3.0 cm by 5.5 cm by 4.2 cm stage IV (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). The wound bed description was noted to have yellow slough, with edge of blacked eschar; the amount of drainage was heavy brown, odor present, tunneling at deepest was (4.2 cm at 12:00); (2.0 cm at 1:00); (2.3 cm at 9:00); (3.0 cm at 11:00). In addition the wound edges were black, rolled, intact and there was pain associated with wound.

-A nurse practitioner (NP) note dated 12/11/20, indicated R1 had been evaluated for an unspecified open wound in the buttock for a worsening wound on the sacrum. NP noted "Today large amount of serosanguinous drainage which has foul odor to it. Tunneling today. Patient feels warm today to touch." The treatment plan by the NP was Augmentin 875/125 milligram (mg) give 1 tablet by mouth every 12 hours for 7 days and dressing for the coccyx wound was cleansed, skin prep to periwound, silver alginate and a large dressing.

-A nursing change of condition progress note dated 12/12/20 at 9:38 a.m. identified R1 had decreased blood pressure, increased heart rate and increased respirations. Vital signs were listed as B/P 88/48, Pulse 107, and respirations 22. "Background: Resident has coccyx wound that is infected. NP assessed wound yesterday and new order for Augmentin initiated yesterday evening." The note also indicated the abnormal vital signs had been identified at 8:30 a.m. and the on-call

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provider was notified and gave an order to send R1 to the hospital.

-A nursing note dated 12/14/20, at 10:34 a.m. indicated R1 had been admitted to the hospital related to sepsis from his coccyx wound and was undergoing surgical irrigation and debridement.

On 12/21/20, at 8:57 a.m. R1 was observed lying in bed with the head of the bed at least 80 degrees. R1 was noted to be asleep and the breakfast tray was right in front of R1.
-At 9:04 a.m. to 10:22 a.m. nursing assistant (NA)-A was observed go in and out of R1's room to encourage R1 to eat and also provided assistance to R1 with eating.
-At 10:26 a.m. NA-A and NA-B were observed to provide R1 with incontinence cares and then turned and repositioned R1. During the observation, R1 was observed with a large clean dry and intact dressing on the coccyx area when NA's rolled R1 side to side.

On 12/21/20, at 11:40 a.m. registered nurse (RN)-C (nurse manager) stated the wound assessment dated 12/4/20, had been completed by RN-B (nurse manager). RN-C stated she was not aware R1 had a pressure ulcer until 12/7/20. RN-C stated RN-B covered her floor while she had been out of the facility from 11/29-12/7/20. RN-C also stated R1 required total assistance and staff were supposed to report any skin concerns to the nurse to be assessed or anything that was not normal with the residents.

On 12/21/20, at 11:37 a.m. nursing assistant (NA)-A stated she was not certain when the wound had started however, she had assisted the nurses, "to patch it up a few times." NA-A also

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stated "the wound got worse and [R1] was sent to the hospital. The nurse knew he had the wound because they were doing the patching up. We thought they were looking at it."

On 12/21/20, at 12:08 p.m. RN-B nurse manager stated she first became aware of pressure ulcer on 12/4/20, when NA-B came and got her and stated they wanted her to see the wound. She measured the wound and got doctors orders and when she went to look at the admission form she noticed there was no wound noted. She then entered the measurements into the form because she assumed RN-A did not do a skin assessment and she had not asked the nurse who had done the assessment if resident had any wounds. At the time she assessed the wound, it was significant and she then got a treatment order for the wound to be done by the nurses daily. RN-B also stated the nurses were to monitor the wound progress and report to her or RN-C if there was concerns because they assess wounds weekly. RN-B then stated she had followed up with NA-B to find out if the skin concern had been reported to a nurse, and NA-B had stated he had reported to RN-A two other times prior to reporting the concern to her because she was next in line to report the concern to. RN-B stated it was possible R1 had developed the pressure wound in the facility care. RN-B then stated she had not asked when NA-B when he had seen the pressure wound first and when she spoke to him as their conversation was in passing during break and that's when NA-B told her he had told RN-A. RN-B stated as soon as she had assessed the wound she got the orders and the nurses were supposed to do the dressing change daily and during the wound treatment they were supposed to monitor the state of the wound and if there

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were any concerns they were to let her know or call the nurse practitioner. RN-B stated she did not hear any concerns about the wound until on 12/11/20, when she and the nurse practitioner had assessed the wound and found the wound had tunneling, had a foul smell, a lot of drainage and R1 felt warm. RN-B stated at that time the nurse practitioner started R1 on an antibiotic and treatment for the wound however, the next day R1 had abnormal vital signs and was sent to the hospital. RN-B acknowledged the nurses failed to monitor and update the provider to re-evaluate the treatment plan.

-At 12:37 p.m. RN-B stated following the incident the facility was providing education to RN-A and all the other nurses. RN-A stated the NA's had not been trained also. During the interview the consultant nurse, RN-D stated all the rest of the training was going to be started and was not going to be delayed. The consultant RN stated the pressure ulcer should have been caught earlier because R1 required total assistance and this was going to be addressed immediately.

On 12/21/20, at 1:08 p.m. the DON stated she had spoken to RN-A about some of the concerns with wound assessment, on going monitoring, re-evaluating interventions and updating the provider on the worsening of the wound. The DON stated she had started to provide education to the nurses and some had been completed on 12/17/20 and 12/18/20, however not all the nurses had received the training at the time. The DON also stated NA's training was not happening until 12/23/20. The consultant RN stated training for the NA's was going to be started then and was not going to wait. "We will teach them as they come and the session will capture who is left."

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At 1:35 p.m. the DON stated her first recollection of the pressure ulcer was when RN-A had documented the wound had been found on 12/3/20. The DON stated she was made aware of the severity of the pressure ulcer after R1 was re-admitted to the hospital by the hospital coordinator. The DON said, "we dropped the ball on this one for sure."

On 12/22/20, at 2:17 p.m. RN-A stated he was not aware of the pressure ulcer and did not remember anything being reported to him until 12/3/20. RN-A stated after he had seen the wound he had written a progress note and thought the nurse managers would follow up with the provider. RN-A acknowledged he did not know he was supposed to assess the wound at the time however he had cleaned the wound and applied a dressing on it. RN-A stated when he was doing the wound care on 12/3/20, after NA-B had reported to him, R1 did show signs and symptoms of pain as R1 was screaming but he was not sure if the pain was from the surgical hip or the pressure ulcer. RN-A also stated the wound looked "reddish and pink at the time, no tunneling and was not that deep. The drainage was not smelling." RN-A stated since the incident he had received training from the DON.

On 12/22/20, at 3:02 p.m. via telephone the NP stated she had been informed the nurse on the floor RN-D was concerned about the wound getting worse and wanted her to see it. The NP stated "We went into the room myself and [RN-B] to assess the wound and I found on that Friday the wound had been tunneling for the past couple days. They had first noticed it on 12/4/20. At that time I wrote orders to start the packed dressing and an antibiotic for [R1]." The NP stated she

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would have expected the staff to have called her in between the time the wound was identified and the date she saw it. The NP also stated If the nurses were seeing signs of an infection they were supposed to let her know to avoid worsening the wound which was the case and the wound now needed a different level of care. The NP further stated it was hard to say but there was a potential if R1 had been started on antibiotic sooner than 12/11/20, it would have prevented R1 being septic.

The facility Skin Assessment and Wound Management dated July 2018, directed staff to perform routine skin inspections (with daily care), Nurses were to be notified if skin changes are identified and weekly skin inspection were to be completed by licensed staff. In addition, the policy directed staff when a new pressure ulcer was identified
the following actions were to be taken:
1) Notify MD/Treatment Ordered
2) Notify resident representative
3) Complete education with resident/resident representative including risks & benefits
4) Initiate Weekly Pressure Wound Evaluation
5) Notify Nurse Manager/Wound Nurse
6) Complete Braden Scale
7) Complete Tissue Tolerance Observation (lying and sitting)
8) Complete Tissue Tolerance Evaluation
9) Referral to dietary, if appropriate
10) Referral to therapies, appropriate
11) Update Care Plan
12) Update resident care lists

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 4, 2021

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: NHJJ11

Dear Administrator:

The above facility was surveyed on December 21, 2020 through December 22, 2020 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:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	00948	A. BUILDING: _____ B. WING _____	C 12/22/2020

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THE ESTATES AT LINDEN LLC	105 WEST LINDEN STREET STILLWATER, MN 55082

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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 December 21, & 22, 2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5337044C/MN00068225 with a licensing order issued at 0900. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
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 monitor, re-evaluate, modify interventions/treatment and notify the physician of a worsening pressure ulcer for 1 of 2 residents (R1) who developed a stage III pressure ulcer (Full thickness skin loss. Subcutaneous fat may be visible but bone,	2 900	corrected	1/14/21

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2 900	Continued From page 2	2 900		

tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling) at the facility. The failure resulted in actual harm for R1 who required hospitalization for sepsis related to an infected pressure ulcer and debridement (a procedure that involves thoroughly cleaning the wound and removing infected, and necrotic or dead tissue) reviewed for pressure ulcers.

Findings include:

R1's admission Minimum Data Set (MDS) dated 11/30/20, identified R1 had severe cognitive impairment and required extensive to total assistance for all activities of daily living including transfers, bed mobility, getting dressed, toilet use and eating. The MDS identified R1 was always incontinent of bladder and bowel. The MDS identified R1 did not have a pressure ulcer, but had a surgical wound, was at risk to develop pressure ulcers, did not reject cares but had physical behavioral symptoms towards others including hitting. Pressure reducing devices had been applied for the chair and the bed. Further, the MDS identified R1 diagnoses included dementia and fracture of unspecified part of neck of left femur.

R1's pressure ulcer/injury Care Area Assessment dated 12/7/20, identified R1 was at risk for skin breakdown due to but not limited to: recent admission to facility, incontinent of bowel et bladder, cognitive impairments, dependent on staff for all repositioning and bed mobility. The CAA directed staff to reposition R1 every two to three hours and as needed, to complete weekly skin assessments by nurse and the nurses were to update the physician with any signs and symptoms of skin breakdown

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2 900	Continued From page 3 R1's care plan dated 11/24/20, identified R1 admitted to the facility 11/24/20, had a deficit in self-care and mobility and directed staff to assist. The care plan did not identify R1 was at risk for pressure ulcers, however on the undated nursing assistant care sheet staff were directed to turn and reposition, R1 every two hours. R1's medical record was reviewed and included the following entries related to skin: -Braden Scale Score Risks (a tool used to predict pressure ulcer risk), conducted on 11/25/20, 12/2/20 and 12/9/20, all identified a score of 18 (15-18: mild risk for breakdown). -MHM Weekly Skin Inspection, "Admission" assessment, dated 11/29/20, identified no new skin issues noted. Documentation lacked information to identify what the skin had looked like to determine what, "no new issues" referenced. -Progress Note dated 12/3/20, indicated "Resident has a wound on his coccyx that writer found today, cleansed and dried and wound dressings applied." There was no indication an assessment of the PU had been completed, to identify PU stage, size, depth, drainage, odor or pain. -MHM Weekly Pressure Wound Evaluation, dated 12/4/20, identified R1 had a stage III wound in the sacrum area which measured 3.0 centimeters (cm) by 3.5 cm by 1.0 cm. and the description of wound was it had an ample amount of slough (Non-viable yellow, tan, gray, green or brown tissues, usually moist, can be soft, stringy, and mucinous in texture) and eschar (Dead or	2 900		

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2 900	Continued From page 4 devitalized tissue that is hard or soft in texture, usually black, brown, or tan in color and may appear like a scab). The interventions implemented included air mattress to be delivered and per the assessment. The physician was contacted and treatment orders to cleanse, skin prep peri wound, silver alginate and apply a large foam dressing. The evaluation also identified, referral to dietary, referral to therapies, notifying the nurse manager/wound nurse and initiate weekly pressure wound evaluation. -MHM Weekly Skin Inspection dated 12/6/20, identified R1 had wound around his coccyx, however no description of the status of the wound was noted on the assessment. -December treatment administration record (TAR) revealed an order with start date 12/5/20, directed staff to "Cleanse, skin prep periwound, silver Alginate, large foam dressing in the morning wound care." During further review of the TAR it was revealed from 12/5/20, through 12/10/20, R1's wound treatment had been signed off as completed however, the medical record lacked documentation of the status of the wound, whether drainage was present, status of the area surrounding the pressure ulcer, possible complications such as signs of increasing area or soft tissue infection and pain. -MHM Weekly Pressure Wound Evaluation, dated 12/11/20, identified R1 had a wound in the coccyx which measured 3.0 cm by 5.5 cm by 4.2 cm stage IV (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). The wound bed description was noted to have yellow slough, with edge of blacked eschar; the amount	2 900		

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2 900	Continued From page 5	2 900		

of drainage was heavy brown, odor present, tunneling at deepest was (4.2 cm at 12:00); (2.0 cm at 1:00); (2.3 cm at 9:00); (3.0 cm at 11:00). In addition the wound edges were black, rolled, intact and there was pain associated with wound.

-A nurse practitioner (NP) note dated 12/11/20, indicated R1 had been evaluated for an unspecified open wound in the buttock for a worsening wound on the sacrum. NP noted "Today large amount of serosanguinous drainage which has foul odor to it. Tunneling today. Patient feels warm today to touch." The treatment plan by the NP was Augmentin 875/125 milligram (mg) give 1 tablet by mouth every 12 hours for 7 days and dressing for the coccyx wound was cleansed, skin prep to periwound, silver alginate and a large dressing.

-A nursing change of condition progress note dated 12/12/20 at 9:38 a.m. identified R1 had decreased blood pressure, increased heart rate and increased respirations. Vital signs were listed as B/P 88/48, Pulse 107, and respirations 22. "Background: Resident has coccyx wound that is infected. NP assessed wound yesterday and new order for Augmentin initiated yesterday evening." The note also indicated the abnormal vital signs had been identified at 8:30 a.m. and the on-call provider was notified and gave an order to send R1 to the hospital.

-A nursing note dated 12/14/20, at 10:34 a.m. indicated R1 had been admitted to the hospital related to sepsis from his coccyx wound and was undergoing surgical irrigation and debridement.

On 12/21/20, at 8:57 a.m. R1 was observed lying in bed with the head of the bed at least 80 degrees. R1 was noted to be asleep and the

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2 900	Continued From page 6	2 900		

breakfast tray was right in front of R1.
-At 9:04 a.m. to 10:22 a.m. nursing assistant (NA)-A was observed go in and out of R1's room to encourage R1 to eat and also provided assistance to R1 with eating.
-At 10:26 a.m. NA-A and NA-B were observed to provide R1 with incontinence cares and then turned and repositioned R1. During the observation, R1 was observed with a large clean dry and intact dressing on the coccyx area when NA's rolled R1 side to side.

On 12/21/20, at 11:40 a.m. registered nurse (RN)-C (nurse manager) stated the wound assessment dated 12/4/20, had been completed by RN-B (nurse manager). RN-C stated she was not aware R1 had a pressure ulcer until 12/7/20. RN-C stated RN-B covered her floor while she had been out of the facility from 11/29-12/7/20. RN-C also stated R1 required total assistance and staff were supposed to report any skin concerns to the nurse to be assessed or anything that was not normal with the residents.

On 12/21/20, at 11:37 a.m. nursing assistant (NA)-A stated she was not certain when the wound had started however, she had assisted the nurses, "to patch it up a few times." NA-A also stated "the wound got worse and [R1] was sent to the hospital. The nurse knew he had the wound because they were doing the patching up. We thought they were looking at it."

On 12/21/20, at 12:08 p.m. RN-B nurse manager stated she first became aware of pressure ulcer on 12/4/20, when NA-B came and got her and stated they wanted her to see the wound. She measured the wound and got doctors orders and when she went to look at the admission form she noticed there was no wound noted. She then

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2 900	Continued From page 7 entered the measurements into the form because she assumed RN-A did not do a skin assessment and she had not asked the nurse who had done the assessment if resident had any wounds. At the time she assessed the wound, it was significant and she then got a treatment order for the wound to be done by the nurses daily. RN-B also stated the nurses were to monitor the wound progress and report to her or RN-C if there was concerns because they assess wounds weekly. RN-B then stated she had followed up with NA-B to find out if the skin concern had been reported to a nurse, and NA-B had stated he had reported to RN-A two other times prior to reporting the concern to her because she was next in line to report the concern to. RN-B stated it was possible R1 had developed the pressure wound in the facility care. RN-B then stated she had not asked when NA-B when he had seen the pressure wound first and when she spoke to him as their conversation was in passing during break and that's when NA-B told her he had told RN-A. RN-B stated as soon as she had assessed the wound she got the orders and the nurses were supposed to do the dressing change daily and during the wound treatment they were supposed to monitor the state of the wound and if there were any concerns they were to let her know or call the nurse practitioner. RN-B stated she did not hear any concerns about the wound until on 12/11/20, when she and the nurse practitioner had assessed the wound and found the wound had tunneling, had a foul smell, a lot of drainage and R1 felt warm. RN-B stated at that time the nurse practitioner started R1 on an antibiotic and treatment for the wound however, the next day R1 had abnormal vital signs and was sent to the hospital. RN-B acknowledged the nurses failed to monitor and update the provider to re-evaluate the treatment plan.	2 900		

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2 900	Continued From page 8 -At 12:37 p.m. RN-B stated following the incident the facility was providing education to RN-A and all the other nurses. RN-A stated the NA's had not been trained also. During the interview the consultant nurse, RN-D stated all the rest of the training was going to be started and was not going to be delayed. The consultant RN stated the pressure ulcer should have been caught earlier because R1 required total assistance and this was going to be addressed immediately. On 12/21/20, at 1:08 p.m. the DON stated she had spoken to RN-A about some of the concerns with wound assessment, on going monitoring, re-evaluating interventions and updating the provider on the worsening of the wound. The DON stated she had started to provide education to the nurses and some had been completed on 12/17/20 and 12/18/20, however not all the nurses had received the training at the time. The DON also stated NA's training was not happening until 12/23/20. The consultant RN stated training for the NA's was going to be started then and was not going to wait. "We will teach them as they come and the session will capture who is left." At 1:35 p.m. the DON stated her first recollection of the pressure ulcer was when RN-A had documented the wound had been found on 12/3/20. The DON stated she was made aware of the severity of the pressure ulcer after R1 was re-admitted to the hospital by the hospital coordinator. The DON said, "we dropped the ball on this one for sure." On 12/22/20, at 2:17 p.m. RN-A stated he was not aware of the pressure ulcer and did not remember anything being reported to him until 12/3/20. RN-A stated after he had seen the wound he had written a progress note and	2 900		

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2 900	Continued From page 9	2 900		

thought the nurse managers would follow up with the provider. RN-A acknowledged he did not know he was supposed to assess the wound at the time however he had cleaned the wound and applied a dressing on it. RN-A stated when he was doing the wound care on 12/3/20, after NA-B had reported to him, R1 did show signs and symptoms of pain as R1 was screaming but he was not sure if the pain was from the surgical hip or the pressure ulcer. RN-A also stated the wound looked "reddish and pink at the time, no tunneling and was not that deep. The drainage was not smelling." RN-A stated since the incident he had received training from the DON.

On 12/22/20, at 3:02 p.m. via telephone the NP stated she had been informed the nurse on the floor RN-D was concerned about the wound getting worse and wanted her to see it. The NP stated "We went into the room myself and [RN-B] to assess the wound and I found on that Friday the wound had been tunneling for the past couple days. They had first noticed it on 12/4/20. At that time I wrote orders to start the packed dressing and an antibiotic for [R1]." The NP stated she would have expected the staff to have called her in between the time the wound was identified and the date she saw it. The NP also stated If the nurses were seeing signs of an infection they were supposed to let her know to avoid worsening the wound which was the case and the wound now needed a different level of care. The NP further stated it was hard to say but there was a potential if R1 had been started on antibiotic sooner than 12/11/20, it would have prevented R1 being septic.

The facility Skin Assessment and Wound Management dated July 2018, directed staff to perform routine skin inspections (with daily care),

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2 900	Continued From page 10 Nurses were to be notified if skin changes are identified and weekly skin inspection were to be completed by licensed staff. In addition, the policy directed staff when a new pressure ulcer was identified the following actions were to be taken: 1) Notify MD/Treatment Ordered 2) Notify resident representative 3) Complete education with resident/resident representative including risks & benefits 4) Initiate Weekly Pressure Wound Evaluation 5) Notify Nurse Manager/Wound Nurse 6) Complete Braden Scale 7) Complete Tissue Tolerance Observation (lying and sitting) 8) Complete Tissue Tolerance Evaluation 9) Referral to dietary, if appropriate 10) Referral to therapies, appropriate 11) Update Care Plan 12) Update resident care lists SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		