Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 4, 2024

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: November 20, 2023

Dear Administrator:

On December 28, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

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January 4, 2024

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Re: Reinspection Results
Event ID: CY7X12

Dear Administrator:

On December 28, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 20, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

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December 8, 2023

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: November 20, 2023

Dear Administrator:

On November 20, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);

- Civil money penalty (42 CFR 488.430 through 488.444).

- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by February 20, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 20, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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December 8, 2023

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Re: State Nursing Home Licensing Orders
Event ID: CY7X11

Dear Administrator:

The above facility was surveyed on November 16, 2023 through November 20, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING ______ B. WING ______	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(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 11/16/23 through 11/20/23, 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. H53947242C (MN00098556) H53947136C (MN00098593) H53947137C (MN00098470) with a deficiency issued at (F656, F684, F686, F689) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		12/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/14/2023

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

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F 656	Continued From page 1 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to failed to follow the comprehensive care plan for supervision for 1 of 1 resident (R2) reviewed for accidents.	F 656	Immediate Corrective Action: Resident has discharged	

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THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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F 656	Continued From page 2 Findings include: R2's Face Sheet identified R3 had the following diagnoses: Dementia and symptoms and signs involving cognitive functions and awareness. R2's significant change Minimum Data Set (MDS) dated 11/3/23 identified R2 was dependent on staff for all transfers including the ability to go from sit to standing position. R2's care plan dated 7/22/22 identified R2 was at risk for elopement due to cognitive impairment and staff were to allow R2 to crawl with supervision due to inability to redirect and risk of falls. R2's care plan dated 9/28/23 identified R2 was at risk of self-care deficits due to cognitive deficits and staff were to keep R2's bedroom door open, the wheelchair removed from the room when R2 was crawling on the floor, trash can emptied immediately after use and ensure surroundings are clear. During observation on 11/16/23 at 11:08 a.m., R2 was behind nurses station with registered nurse (RN)-A . R2 was crawling. RN-A left the nurses station leaving R2 unsupervised. R2 continued to crawl in nurses station placing floor debris in mouth and appeared to be chewing. R2 reached and grabbed on to items in reach such as a cup and an ice scoop placing items to mouth. During observation on 11/17/23 at 4:00 p.m., R2 was in room with door closed crawling on floor unsupervised with wheelchair in room and assessable to R2.	F 656	Corrective Action as it applies to others: Reviewed all residents care plans to identify all that require supervision, and to ensure that care plans are accurate in regards to supervision needed. Process: No changes needed Education: IDT has been educated regarding the definition of supervision, and to utilize that word appropriately when care planning Began educating nursing department in regards to following plan of care including the information on the ADL sheets Recurrence will be prevented by: Audit 5 resident care plans weekly for 4 weeks to ensure supervision is appropriate and being followed. These results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits Corrections will be monitored by: Admin and DON or designee Date of Compliance: 12/22/23	

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F 656	Continued From page 3	F 656		

During interview on 11/20/23 l0:39 a.m., licensed practical nurse (LPN)-A indicated R2's preference was to crawl and staff should be supervising when she was crawling. When R2 was in her room the door should be open and the wheelchair out of the room due to the risk of it tipping over. Staff were to keep her environment clutter free. LPN-A indicated R2 was not to be behind the nurses station unsupervised.

During interview on 11/20/23 10:47 a.m., nurse manager (NM)-A indicated R2 was to be supervised any time she was crawling on the floor. R2 was not to be behind the nurses station unsupervised. NM-A indicated R2 required supervision due to risk of choking and requires monitoring due to negative interactions with other residents.

During observation on 11/20/23 at 12:19 p.m., R2 was in her room with the door open and room curtain divider drawn. R2 was crawling around on the floor eating particles of debris off floor. R2 crawled to wheelchair unsupervised and without staff intervention.

During interview on 11/20/23 at 1:30 p.m., DON indicated R2 was not to be behind the nurses station supervised or not. R2 was to be supervised at all times while crawling including in her room with the door open.

Policy titled Care Planning interdisciplinary team dated 7/2123, identifies the facility's Care Planning/Interdisciplinary Team to be responsible for the development of an individualized comprehensive care plan for each resident.

Policy Interpretation and Implementation:

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F 656	Continued From page 4	F 656		

A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS).
" The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel:
o The resident's Attending Physician.
o The Registered Nurse who has responsibility for the resident.
o The Dietary Manager/Dietician.
o The Social Services Worker/Social Services Designee responsible for the resident.
o The Activity/TR Director.
o Therapists (speech, occupational, physical ect. (as applicable).
o Consultants (as applicable).
o The Director of Nursing (as applicable).
o The Floor Nurse responsible for resident care (as applicable).
o Nursing Assistants responsible for the resident's care (as applicable0.
o Others as appropriate or necessary to meet the needs of the resident.
" The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan.
" Every effort will be made to schedule IDT care plan meetings at the best time of the day for the resident and family.
" The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary care plan (e.g., face-to-face, teleconference, written communication, etc.) is at the discretion of the

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F 656	Continued From page 5 IDT Team.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess skin for 1 of 1 resident (R4) who had injury of unknown source, additionally failed to notify physician in a timely manner. Findings include: R4's Face Sheet identified R10 had a diagnoses which included schizophrenia and seizures R4's care plan dated 11/6/23 identified R4 was at risk for skin alteration. The care plan directed staff to monitor R4's skin integrity during cares, weekly skin inspections by the nurse, and provide treatment to open areas per order. R4's admission Minimum Data Set (MDS) dated 11/9/23 does not identify skin tears or other open lesions. R4's order dated 11/20/23 identified for staff to monitor scab to right inner thigh for	F 684	Immediate Corrective Action: • Resident has discharged Corrective Action as it applies to others: • Skin assessment was completed for all residents Process reviewed and any changes • No changes needed Education: • Re-education notifications of skin concerns with cares (CNAs) • Re-education to nurses for what to do when a skin issue arises • Re-education for weekly skin • What would you do if it is an unknown source (call DON immediately if unknown) • Skin and wound policy • Abuse policy Recurrence will be prevented by: • Audit weekly skin assessments and	12/22/23

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F 684	Continued From page 6 signs/symptoms of infection until healed. Update nurse practitioner as needed. R4's Skin Assessment dated 11/10/23, identified redness to R4's bottom and feeding tube site. No open areas noted. During interview on 11/16/23 at 1:22 p.m. family member (FM)-A expressed concerns that R4 had a "large gash" on right upper leg that was not being addressed by nursing staff further describing the area as a scratch. to be scratch like During observation at 2:07 p.m. FM-A pointed to area of concern; R4 had an abrasion to right anterior thigh about 4 centimeters long; the abrasion had a scab that was dark in color with no open areas. R4's Skin Assessment dated 11/17/23, did not identify the presence of the abrasion on R4's thigh. In review of R4's skin assessments and progress notes between 11/1/23 through 11/16/23, it was not evident R4's thigh abrasion had been identified prior to 11/17/23. Incident report dated 11/17/23 identified R4 had an abrasion on right anterior thigh which may have been from scratching himself. Area dry, no signs of infection noted. Resident fidgets and attempts to pull on tubing or skin. Injury noted to be on right thigh as an abrasion. R4's record lacked a comprehensive skin assessment which would include measurements, treatments, and interventions.	F 684	spot checks with looking at skin o 5 per week x4 weeks, 5 per month for 3 months • Audit follow up is completed when skin concern is noted o 5 per week x4 weeks, 5 per month for 3 months • Quizzes with staff o 5 staff members per week x4 weeks, 5 per month for 3 months • These results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits Corrections will be monitored by: • Admin and DON or designee Date of Compliance: • 12/22/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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During interview on 11/20/23 at 11:07 a.m. registered nurse (RN)-B indicated R4 could not move himself and required staff assistance. RN-B explained skin assessment were very important for residents that were unable to reposition themselves. Every time a nursing staff member goes into the room staff observed and assessed residents who could not communicate or were bed bound. RN-B was not aware of R4's abrasion on his thigh.

During interview and observation on 11/20/23 at 11:18 a.m. RN-B and nurse manager (NM)-A were in R4's room to complete a skin assessment to R4's right leg. They identified the right thigh abrasion described as scratch mark which measured 4.0 centimeters (cm) long, 0.5 cm wide and full area 8.5 cm by 2.0 cm. Area reported to be superficial and scabbed.

During interview on 11/20/23 at 11:53 a.m., NM-A indicated R4 was at risk for skin concerns due to physical limitations. NM-A reviewed R4's record and confirmed R4's record did not identify the right leg laceration. NM-A indicated there was no documentation or notations on skin assessments including the incident report from 11/17/23 that addressed the right leg abrasion. NM-A indicated the abrasion was an injury of unknown source that was still being investigated.

During interview on 11/20/23 at 2:51 p.m., nurse practitioner (NP)-A indicated R4 was at high risk of skin concerns and should be monitored closely. NP-A indicated she was notified about a scab to right thigh on this day 11/20/23, however nothing prior. NP-A indicated R4 had a history of pulling at things and scratching. NP-A would

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expect any injury of unknown source to be monitored, assessed, and addressed in a timely fashioned.

Policy titled Skin Assessment and Wound Management dated 11/17/23, The purpose is to Provide guidelines for assessing and managing wounds.

" A pressure ulcer risk assessment (Braden Scale) will be completed per
" Monarch's Assessment Schedule/Grid.
" Implement appropriate preventative skin measures.
" Skin Evaluation and Skin Risk Factors Form is completed on
" admission, annually, and upon significant change.
" Staff will perform routine skin inspections (with daily care).
" Nurses are to be notified if skin changes are identified.
" A weekly skin inspection will be completed by licensed staff.

For Non-Pressure wounds and altered skin integrity for new skin problems: 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:

" 7. Notify Provider/Treatment Ordered
" 8. Notify resident representative.
" 9. Complete education with resident/resident representative including
" risks & benefits.
" 10.Initiate Skin and Wound Evaluation

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F 684	Continued From page 9 " 11.Notify Nurse Manager/Wound Nurse " 12.Referral to dietary, if appropriate " 13.Referral to therapies, if appropriate " 14.Review and update care plan including interventions. " 15.Update resident care lists " 16.Update Care Plan to identify risks for skin breakdown	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (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, document review the facility failed to follow the care plan for pressure reducing/relieving interventions to prevent or mitigate the risk of deterioration or prevention of new pressure ulcer development for 1 of 1 residents (R4) who had impaired skin integrity and was at high risk for pressure ulcers. Findings include: R4's Face Sheet identified R4 had the following	F 686	Immediate Corrective Action: • Resident has discharged Corrective Action as it applies to others: • Full house audit of Braden scores to identify anyone who is 18 or below o Then check those residents last skin eval and risk factor form says for their turn and repo and make sure turn and repo is on care plan and NAR guide o Redo skin eval and risk factor if turn	12/22/23

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F 686	Continued From page 10 diagnoses: Aphasia following a cerebral infarction. R4's admission assessment Minimum Data Set (MDS) dated 11/09/23 identified R4 was at risk of pressure ulcers, had no unhealed pressure ulcers, and had moisture related skin damage (MASD). Skin and ulcer treatments included application of non-surgical dressings and application of ointments or medications. R4's care plan dated 11/6/23, identified R4 was at risk of alteration in skin integrity due to diagnosis. R4 admitted with MASD on coccyx , preferred to lay on back and frequently refused turning and repositioning. Removes heel protectors if attempting to apply. Staff were to monitor skin integrity daily during cares, weekly skin inspection by nurse, treatment to open area per order, and turn and reposition every two to three hours hours and as needed. R4's weekly skin inspection dated 11/3/23, identified R4 had noted moisture related redness to his bottom. No open areas noted. The skin inspection had no other description and measurements of the impaired skin integrity. R4's skin evaluation and skin risk factors dated 11/6/23, identified R4 had moisture related redness on coccyx (tailbone), however not stageable. The skin evaluation had no other description and measurements of the impaired skin integrity. R4's wound care note dated 11/7/23, included R4 was seen for an evaluation of MASD on the coccyx region (tailbone). Education provided to patient about offloading pressure, controlling	F 686	and repo is not in there Process: • No changes needed Education: • CNAs follow ADL sheets for turning and repositioning • Nurses are responsible for overseeing CNAs to ensure they are following plan of care including turning and repositioning • Educate staff to audit process Recurrence will be prevented by: o Audit 5 residents per week x4 weeks, 5 per month for 3 months to ensure turning and repositioning plan was followed • These results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits Corrections will be monitored by: • Admin and DON or designee Date of Compliance: • 12/22/23	

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moisture, keeping area clean and dry, and frequent incontinent checks and changes. Patients cognitive status not intact, unable to understand education given, encouraged staff to follow through with protocol. Reduced mobility, difficulty walking and muscle weakness predisposes patient to wounds due to weakness and inability to move or reposition. Reposition per facility protocol/policy. The wound note had no other description and measurements of the impaired skin integrity.

R4's weekly skin inspection dated 11/10/23, indicated R4 had redness to his bottom. No open areas noted. The skin inspection had no other description and measurements of the impaired skin integrity.

R4's wound care note dated 11/14/23, indicated the area on R4's bottom appeared stable/improved with small superficial areas to the coccyx and barrier cream to be continued for protection. Patients cognitive status not intact, unable to understand education given, encouraged staff to follow through with frequent turns and incontinence checks.

R4's skin and wound evaluation dated 11/14/23, indicated the area to be 5.3 cm2 length 4.1 cm, and width 1.8 cm.

R4's weekly skin inspection dated 11/17/23, identified open area on coccyx reassessed, shows improvement from admission. Redness to left buttock also, shows improvement. No signs of infection noted. Will continue with current treatment and intervention.

During interview on 11/16/23 at 1:22 p.m., family

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F 686	Continued From page 12 member (FM)-A indicated facility staff were not turning or repositioning R4 and not offering to get R4 out of bed. FM-A expressed concerns about R4 being in the same position for hours and reported R4 had a sore on his bottom that wasn't being addressed. During continuous observation on 11/17/23 from 8:41 a.m. to 1:32 p.m. R4 was positioned on his back with head of the bed raised to 45 degrees and his heels directly on mattress with socks on. Facility staff entered R4's room every 15-minutes to provide safety checks (malfunctioning call light system), however, did not offer and/or provide turning and repositioning. R4 remained in the same position on his back with heels on the bed. During interview on 11/17/23 at 2:00 p.m. NA-A and NA-B indicated R4 should be turned and repositioned every two hours and a check and changed should be completed every hour. The care plan directs when residents require turning and repositioning. NA's indicated they had not completed repositioning because R4 was sleeping. NA's should have repositioned but R4 had a rough night and wanted to let him sleep. During observation on 11/17/23 at 2:20 p.m., nursing assistant NA-A and NA-B entered room and completed a check and change, however did not reposition. During observation and interview on 11/17/23 at 2:40 p.m. director of nursing (DON) completed a wound measurement and assessed the area to be 5.2 c.m. long by 0.8 cm's wide. DON indicated the tissue was granulated, slightly bleeding and healing/improving. Confirmed redness to left buttock, but closed and skin intact.	F 686		

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F 686	Continued From page 13	F 686		

During interview on 11/20/23 at 11:07 p.m., RN-B indicated R4 was on a turning and repositioning schedule every two hours and it was important to keep R4 off his bottom. Assessing skin was very important for residents who could not reposition themselves, were bed bound, and could not communicate effectively. RN-B indicated R4 required barrier cream to his bottom, repositioned off his bottom to avoid pressure, and his heels offloaded. R4 has offloading boots for his heels and should be worn at all times.

During observation and interview on 11/20/23 at 11:18, R4 laid on his back, his heels were not floated and feet were touching flat against the footboard. RN-B confirmed R4 was observed laying flat on bad and heals were not floated and feet were touching the foot board.

During interview on 11/20/23 at 11:58 p.m., nurse manager (NM)-B indicated R4's was seemed too short and feet should not be touching the footboard. NM-B indicated R4's heals should be floated with use of pneumo boots whenever R4 was in bed and it should be care planned. Turning and repositioning was individualized based on whether the resident could make needs known, exposure to moisture, and risk for break down. NM-B indicated R4 was at risk for skin break down and was care planned for 2-3 hours. Staff should be anticipating needs R4's needs.

During interview on 11/20/23 at 2:44 p.m., RN-C indicated that all staff should be following the care plan. R4's care plan directed an every two to three hours turning and repositioning schedule. RN-C reported she had not turned and repositioned R4 on 11/17/23, between 8:41 a.m.

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to 1:32 p.m. because she felt it was the responsibility of the nursing assistants. RN-C indicated nurses are responsible for offloading heals, if that's what the orders indicated.

During interview on 11/20/23 at 1:30 p.m., Director of Nursing (DON) indicated turning and repositioning scheduled are individualized by residents needs and assessments. Based off R4's Braden score (assessment for pressure related skin injuries) R4 required to be turned and repositioned every two to three hours. DON indicated nursing staff should be turning and repositioning in accordance to the care plan.

During interview on 11/20/23 at 2:51 p.m., Nurse practitioner (NP)-A stated an awareness of a moisture related wound on R4's bottom, however did not know much about it, such as size, coloring or progression. NP-A indicated staff should be turning and repositioning in accordance to care plan and R4 was at high risk for skin breakdown and should be monitored closely. NP-A indicated it would not be appropriate for R4 to go longer go longer than 3 hours without being turned or repositioned.

Braden Scale assessments and skin risk factors forms requested and not received.

Policy for skin and wound management dated 11/17/23 indicates the policy is to Provide guidelines for assessing and managing wounds.
1. A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid.
2. Implement appropriate preventative skin measures.
3. Skin Evaluation and Skin Risk Factors Form is

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F 686	Continued From page 15 completed on admission, annually, and upon significant change. 4. Staff will perform routine skin inspections (with daily care). 5. Nurses are to be notified if skin changes are identified. 6. A weekly skin inspection will be completed by licensed staff. For ongoing skin issues: staff are to update provider and resident/representative as needed and update care plan as needed.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure safe transfers for 1 of 1 residents (R2) who had to be lowered to the floor by staff because wheelchair breaks were not locked prior to the transfer. Findings include: R2's Face Sheet identified R3 had the following diagnoses: dementia and symptoms and signs involving cognitive functions and awareness. R2's significant change Minimum Data Set (MDS) dated 11/3/23 identified R2 was dependent on	F 689	Immediate Corrective Action: • Resident has discharged Corrective Action as it applies to others: • full house audit completed to identify residents that require assistance with transfer Process: • No changes needed Education: • Began education with all nursing staff to lock brakes before assisting resident	12/22/23

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F 689	Continued From page 16 staff for all transfers including the ability to go from sit to standing position. R2's care plan dated 6/9/22 identified R2 had a potential for falls due to unsteady balance and daily use of antidepressant medication. R2 will intermittently sit or kneel on the floor unassisted and will attempt to stand up independently at times. R2 is restless and often attempts to get out of wheelchair and crawl on the floor. R2 becomes agitated and resistive when redirected not to crawl on the floor. Staff were to place R2 by the nursing station for close observation whenever able when R2 is out of bed. During observation on 11/16/23 at 11:08 a.m., R2 was crawling around behind the nurses' station, registered nurse (RN)-A was also behind the nurses'. RN-A attempted to transfer R2 from floor to a wheelchair, however the brakes were not locked and RN-A did not lock the wheelchair breaks to prevent the chair from moving. As RN-A attempted to assist R2 into the chair, the chair rolled backward, and R2 was lowered to the floor by RN-A. During interview on 11/17/23 at 4:41 p.m., RN-A indicated she was trying to get R2 up into the wheelchair, however the wheelchair breaks were not locked and needed to lower R2 to the floor. During interview on 11/20/23 10:47 a.m., nurse manager (NM)-A indicated no "near falls" or lowering a resident to floor had been reported for R2. NM-A explained lowering a resident to the floor was considered a fall. All staff were aware of requirements for fall reporting and documentation.	F 689	into wheelchair Recurrence will be prevented by: • Audit transfers of 5 residents per week for 4 weeks to ensure staff locking brakes prior to transferring into wc • These results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits Corrections will be monitored by: • Admin and DON or designee Date of Compliance: • 12/22/23	

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F 689	Continued From page 17 During interview on 11/20/23 at 1:30 p.m., director of nursing (DON) was unaware of a near fall or lowering to the ground for R2. All near falls should be reported and a risk management report should be done. All staff should be locking wheelchair brakes prior to transfers. Fall policy dated 9/23 identifies the purpose of The purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Nursing staff will complete a Fall Risk Evaluation to identify and document resident's risk factors for falls upon admission, annually, with a significant changed in condition, and as needed. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Staff are responsible for assessing and Evaluating Falls and Causal Factors, When a Fall occurs, Defining Details of Falls, Identifying Causes of a Fall or Fall Risk, complete Documentation, Notification and Follow-Up and Report to the State Survey Agency	F 689		

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2 000	Initial Comments	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 11/16/23 through 11/20/23, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.

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2 000	Continued From page 1 The following complaints were reviewed. H53947242C (MN00098556) H53947136C (MN00098593) H53947137C (MN00098470) with a licensing order issued at (0565, 0830, 0905) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00945	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to failed to follow the comprehensive care plan for supervision for 1 of 1 resident (R2) reviewed for accidents. Findings include: R2's Face Sheet identified R3 had the following diagnoses: Dementia and symptoms and signs involving cognitive functions and awareness. R2's significant change Minimum Data Set (MDS) dated 11/3/23 identified R2 was dependent on staff for all transfers including the ability to go from sit to standing position. R2's care plan dated 7/22/22 identified R2 was at risk for elopement due to cognitive impairment	2 565	Corrected	12/22/23

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2 565	Continued From page 3	2 565		

and staff were to allow R2 to crawl with supervision due to inability to redirect and risk of falls.
R2's care plan dated 9/28/23 identified R2 was at risk of self-care deficits due to cognitive deficits and staff were to keep R2's bedroom door open, the wheelchair removed from the room when R2 was crawling on the floor, trash can emptied immediately after use and ensure surroundings are clear.

During observation on 11/16/23 at 11:08 a.m., R2 was behind nurses station with registered nurse (RN)-A . R2 was crawling. RN-A left the nurses station leaving R2 unsupervised. R2 continued to crawl in nurses station placing floor debris in mouth and appeared to be chewing. R2 reached and grabbed on to items in reach such as a cup and an ice scoop placing items to mouth.

During observation on 11/17/23 at 4:00 p.m., R2 was in room with door closed crawling on floor unsupervised with wheelchair in room and assessable to R2.

During interview on 11/20/23 l0:39 a.m., licensed practical nurse (LPN)-A indicated R2's preference was to crawl and staff should be supervising when she was crawling. When R2 was in her room the door should be open and the wheelchair out of the room due to the risk of it tipping over. Staff were to keep her environment clutter free. LPN-A indicated R2 was not to be behind the nurses station unsupervised.

During interview on 11/20/23 10:47 a.m., nurse manager (NM)-A indicated R2 was to be supervised any time she was crawling on the floor. R2 was not to be behind the nurses station unsupervised. NM-A indicated R2 required

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2 565	Continued From page 4 supervision due to risk of choking and requires monitoring due to negative interactions with other residents. During observation on 11/20/23 at 12:19 p.m., R2 was in her room with the door open and room curtain divider drawn. R2 was crawling around on the floor eating particles of debris off floor. R2 crawled to wheelchair unsupervised and without staff intervention. During interview on 11/20/23 at 1:30 p.m., DON indicated R2 was not to be behind the nurses station supervised or not. R2 was to be supervised at all times while crawling including in her room with the door open. Policy titled Care Planning interdisciplinary team dated 7/2123, identifies the facility's Care Planning/Interdisciplinary Team to be responsible for the development of an individualized comprehensive care plan for each resident. Policy Interpretation and Implementation: A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS). " The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: o The resident's Attending Physician. o The Registered Nurse who has responsibility for the resident. o The Dietary Manager/Dietician. o The Social Services Worker/Social Services Designee responsible for the resident. o The Activity/TR Director.	2 565		

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2 565	Continued From page 5 o Therapists (speech, occupational, physical ect. (as applicable). o Consultants (as applicable). o The Director of Nursing (as applicable). o The Floor Nurse responsible for resident care (as applicable). o Nursing Assistants responsible for the resident's care (as applicable0. o Others as appropriate or necessary to meet the needs of the resident. " The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. " Every effort will be made to schedule IDT care plan meetings at the best time of the day for the resident and family. " The mechanics of how the Interdisciplinary Team meets its responsibilities in the development of the interdisciplinary care plan (e.g., face-to-face, teleconference, written communication, etc.) is at the discretion of the IDT Team. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures on comprehensive care planning. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents care plans are being followed, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		

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2 830	Continued From page 6	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure safe transfers for 1 of 1 residents (R2) who had to be lowered to the floor by staff because wheelchair breaks were not locked prior to the transfer. Findings include: R2's Face Sheet identified R3 had the following diagnoses: dementia and symptoms and signs involving cognitive functions and awareness. R2's significant change Minimum Data Set (MDS) dated 11/3/23 identified R2 was dependent on staff for all transfers including the ability to go from sit to standing position. R2's care plan dated 6/9/22 identified R2 had a potential for falls due to unsteady balance and daily use of antidepressant medication. R2 will	2 830	Corrected	12/22/23

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2 830	Continued From page 7	2 830		

intermittently sit or kneel on the floor unassisted and will attempt to stand up independently at times. R2 is restless and often attempts to get out of wheelchair and crawl on the floor. R2 becomes agitated and resistive when redirected not to crawl on the floor. Staff were to place R2 by the nursing station for close observation whenever able when R2 is out of bed.

During observation on 11/16/23 at 11:08 a.m., R2 was crawling around behind the nurses' station, registered nurse (RN)-A was also behind the nurses'. RN-A attempted to transfer R2 from floor to a wheelchair, however the brakes were not locked and RN-A did not lock the wheelchair breaks to prevent the chair from moving. As RN-A attempted to assist R2 into the chair, the chair rolled backward, and R2 was lowered to the floor by RN-A.

During interview on 11/17/23 at 4:41 p.m., RN-A indicated she was trying to get R2 up into the wheelchair, however the wheelchair breaks were not locked and needed to lower R2 to the floor.

During interview on 11/20/23 10:47 a.m., nurse manager (NM)-A indicated no "near falls" or lowering a resident to floor had been reported for R2. NM-A explained lowering a resident to the floor was considered a fall. All staff were aware of requirements for fall reporting and documentation.

During interview on 11/20/23 at 1:30 p.m., director of nursing (DON) was unaware of a near fall or lowering to the ground for R2. All near falls should be reported and a risk management report should be done. All staff should be locking wheelchair brakes prior to transfers.

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2 830	Continued From page 8	2 830		

Fall policy dated 9/23 identifies the purpose of The purpose of this protocol is to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the fall. Nursing staff will complete a Fall Risk Evaluation to identify and document resident's risk factors for falls upon admission, annually, with a significant changed in condition, and as needed. Facility staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. Staff are responsible for assessing and Evaluating Falls and Causal Factors, When a Fall occurs, Defining Details of Falls, Identifying Causes of a Fall or Fall Risk, complete Documentation, Notification and Follow-Up and Report to the State Survey Agency

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the

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2 830	Continued From page 9	2 830		

Continued From page 9

policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

Based on observation, interview and document review the facility failed to comprehensively assess skin for 1 of 1 resident (R4) who had injury of unknown source, additionally failed to notify physician in a timely manner.

Findings include:

R4's Face Sheet identified R10 had a diagnoses which included schizophrenia and seizures

R4's care plan dated 11/6/23 identified R4 was at risk for skin alteration. The care plan directed staff to monitor R4's skin integrity during cares, weekly skin inspections by the nurse, and provide treatment to open areas per order.

R4's admission Minimum Data Set (MDS) dated 11/9/23 does not identify skin tears or other open lesions.

R4's order dated 11/20/23 identified for staff to monitor scab to right inner thigh for signs/symptoms of infection until healed. Update nurse practitioner as needed.

R4's Skin Assessment dated 11/10/23, identified redness to R4's bottom and feeding tube site. No open areas noted.

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2 830	Continued From page 10	2 830		

During interview on 11/16/23 at 1:22 p.m. family member (FM)-A expressed concerns that R4 had a "large gash" on right upper leg that was not being addressed by nursing staff further describing the area as a scratch. to be scratch like

During observation at 2:07 p.m. FM-A pointed to area of concern; R4 had an abrasion to right anterior thigh about 4 centimeters long; the abrasion had a scab that was dark in color with no open areas.

R4's Skin Assessment dated 11/17/23, did not identify the presence of the abrasion on R4's thigh.

In review of R4's skin assessments and progress notes between 11/1/23 through 11/16/23, it was not evident R4's thigh abrasion had been identified prior to 11/17/23.

Incident report dated 11/17/23 identified R4 had an abrasion on right anterior thigh which may have been from scratching himself. Area dry, no signs of infection noted. Resident fidgets and attempts to pull on tubing or skin. Injury noted to be on right thigh as an abrasion.

R4's record lacked a comprehensive skin assessment which would include measurements, treatments, and interventions.

During interview on 11/20/23 at 11:07 a.m. registered nurse (RN)-B indicated R4 could not move himself and required staff assistance. RN-B explained skin assessment were very important for residents that were unable to reposition themselves. Every time a nursing staff member goes into the room staff observed and assessed

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2 830	Continued From page 11	2 830		

residents who could not communicate or were bed bound. RN-B was not aware of R4's abrasion on his thigh.

During interview and observation on 11/20/23 at 11:18 a.m. RN-B and nurse manager (NM)-A were in R4's room to complete a skin assessment to R4's right leg. They identified the right thigh abrasion described as scratch mark which measured 4.0 centimeters (cm) long, 0.5 cm wide and full area 8.5 cm by 2.0 cm. Area reported to be superficial and scabbed.

During interview on 11/20/23 at 11:53 a.m., NM-A indicated R4 was at risk for skin concerns due to physical limitations. NM-A reviewed R4's record and confirmed R4's record did not identify the right leg laceration. NM-A indicated there was no documentation or notations on skin assessments including the incident report from 11/17/23 that addressed the right leg abrasion. NM-A indicated the abrasion was an injury of unknown source that was still being investigated.

During interview on 11/20/23 at 2:51 p.m., nurse practitioner (NP)-A indicated R4 was at high risk of skin concerns and should be monitored closely. NP-A indicated she was notified about a scab to right thigh on this day 11/20/23, however nothing prior. NP-A indicated R4 had a history of pulling at things and scratching. NP-A would expect any injury of unknown source to be monitored, assessed, and addressed in a timely fashioned.

Policy titled Skin Assessment and Wound Management dated 11/17/23, The purpose is to Provide guidelines for assessing and managing wounds.

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2 830	Continued From page 12 " A pressure ulcer risk assessment (Braden Scale) will be completed per " Monarch's Assessment Schedule/Grid. " Implement appropriate preventative skin measures. " Skin Evaluation and Skin Risk Factors Form is completed on " admission, annually, and upon significant change. " Staff will perform routine skin inspections (with daily care). " Nurses are to be notified if skin changes are identified. " A weekly skin inspection will be completed by licensed staff. For Non-Pressure wounds and altered skin integrity for new skin problems: 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: " 7. Notify Provider/Treatment Ordered " 8. Notify resident representative. " 9. Complete education with resident/resident representative including " risks & benefits. " 10.Initiate Skin and Wound Evaluation " 11.Notify Nurse Manager/Wound Nurse " 12.Referral to dietary, if appropriate " 13.Referral to therapies, if appropriate " 14.Review and update care plan including interventions. " 15.Update resident care lists " 16.Update Care Plan to identify risks for skin breakdown	2 830		

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2 830	Continued From page 13 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to skin inspections and monitoring residents skins to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, document review the facility failed to follow the care plan for pressure reducing/relieving interventions to prevent or mitigate the risk of deterioration or prevention of new pressure ulcer development for 1 of 1 residents (R4) who had impaired skin integrity and was at high risk for pressure ulcers.	2 905	Corrected	12/22/23

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2 905	Continued From page 14	2 905		

Findings include:

R4's Face Sheet identified R4 had the following diagnoses: Aphasia following a cerebral infarction.

R4's admission assessment Minimum Data Set (MDS) dated 11/09/23 identified R4 was at risk of pressure ulcers, had no unhealed pressure ulcers, and had moisture related skin damage (MASD). Skin and ulcer treatments included application of non-surgical dressings and application of ointments or medications.

R4's care plan dated 11/6/23, identified R4 was at risk of alteration in skin integrity due to diagnosis. R4 admitted with MASD on coccyx , preferred to lay on back and frequently refused turning and repositioning. Removes heel protectors if attempting to apply. Staff were to monitor skin integrity daily during cares, weekly skin inspection by nurse, treatment to open area per order, and turn and reposition every two to three hours hours and as needed.

R4's weekly skin inspection dated 11/3/23, identified R4 had noted moisture related redness to his bottom. No open areas noted. The skin inspection had no other description and measurements of the impaired skin integrity.

R4's skin evaluation and skin risk factors dated 11/6/23, identified R4 had moisture related redness on coccyx (tailbone), however not stageable. The skin evaluation had no other description and measurements of the impaired skin integrity.

R4's wound care note dated 11/7/23, included R4 was seen for an evaluation of MASD on the

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	00945	A. BUILDING: ______ B. WING ______	11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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2 905	Continued From page 15 coccyx region (tailbone). Education provided to patient about offloading pressure, controlling moisture, keeping area clean and dry, and frequent incontinent checks and changes. Patients cognitive status not intact, unable to understand education given, encouraged staff to follow through with protocol. Reduced mobility, difficulty walking and muscle weakness predisposes patient to wounds due to weakness and inability to move or reposition. Reposition per facility protocol/policy. The wound note had no other description and measurements of the impaired skin integrity. R4's weekly skin inspection dated 11/10/23, indicated R4 had redness to his bottom. No open areas noted. The skin inspection had no other description and measurements of the impaired skin integrity. R4's wound care note dated 11/14/23, indicated the area on R4's bottom appeared stable/improved with small superficial areas to the coccyx and barrier cream to be continued for protection. Patients cognitive status not intact, unable to understand education given, encouraged staff to follow through with frequent turns and incontinence checks. R4's skin and wound evaluation dated 11/14/23, indicated the area to be 5.3 cm2 length 4.1 cm, and width 1.8 cm. R4's weekly skin inspection dated 11/17/23, identified open area on coccyx reassessed, shows improvement from admission. Redness to left buttock also, shows improvement. No signs of infection noted. Will continue with current treatment and intervention.	2 905		

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2 905	Continued From page 16	2 905		

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During interview on 11/16/23 at 1:22 p.m., family member (FM)-A indicated facility staff were not turning or repositioning R4 and not offering to get R4 out of bed. FM-A expressed concerns about R4 being in the same position for hours and reported R4 had a sore on his bottom that wasn't being addressed.

During continuous observation on 11/17/23 from 8:41 a.m. to 1:32 p.m. R4 was positioned on his back with head of the bed raised to 45 degrees and his heels directly on mattress with socks on. Facility staff entered R4's room every 15-minutes to provide safety checks (malfunctioning call light system), however, did not offer and/or provide turning and repositioning. R4 remained in the same position on his back with heels on the bed.

During interview on 11/17/23 at 2:00 p.m. NA-A and NA-B indicated R4 should be turned and repositioned every two hours and a check and changed should be completed every hour. The care plan directs when residents require turning and repositioning. NA's indicated they had not completed repositioning because R4 was sleeping. NA's should have repositioned but R4 had a rough night and wanted to let him sleep.

During observation on 11/17/23 at 2:20 p.m., nursing assistant NA-A and NA-B entered room and completed a check and change, however did not reposition.

During observation and interview on 11/17/23 at 2:40 p.m. director of nursing (DON) completed a wound measurement and assessed the area to be 5.2 c.m. long by 0.8 cm's wide. DON indicated the tissue was granulated, slightly bleeding and healing/improving. Confirmed redness to left buttock, but closed and skin intact.

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2 905	Continued From page 17	2 905		

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During interview on 11/20/23 at 11:07 p.m., RN-B indicated R4 was on a turning and repositioning schedule every two hours and it was important to keep R4 off his bottom. Assessing skin was very important for residents who could not reposition themselves, were bed bound, and could not communicate effectively. RN-B indicated R4 required barrier cream to his bottom, repositioned off his bottom to avoid pressure, and his heels offloaded. R4 has offloading boots for his heels and should be worn at all times.

During observation and interview on 11/20/23 at 11:18, R4 laid on his back, his heels were not floated and feet were touching flat against the footboard. RN-B confirmed R4 was observed laying flat on bad and heals were not floated and feet were touching the foot board.

During interview on 11/20/23 at 11:58 p.m., nurse manager (NM)-B indicated R4's was seemed too short and feet should not be touching the footboard. NM-B indicated R4's heals should be floated with use of pneumo boots whenever R4 was in bed and it should be care planned. Turning and repositioning was individualized based on whether the resident could make needs known, exposure to moisture, and risk for break down. NM-B indicated R4 was at risk for skin break down and was care planned for 2-3 hours. Staff should be anticipating needs R4's needs.

During interview on 11/20/23 at 2:44 p.m., RN-C indicated that all staff should be following the care plan. R4's care plan directed an every two to three hours turning and repositioning schedule. RN-C reported she had not turned and repositioned R4 on 11/17/23, between 8:41 a.m. to 1:32 p.m. because she felt it was the

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2 905	Continued From page 18 responsibility of the nursing assistants. RN-C indicated nurses are responsible for offloading heals, if that's what the orders indicated. During interview on 11/20/23 at 1:30 p.m., Director of Nursing (DON) indicated turning and repositioning scheduled are individualized by residents needs and assessments. Based off R4's Braden score (assessment for pressure related skin injuries) R4 required to be turned and repositioned every two to three hours. DON indicated nursing staff should be turning and repositioning in accordance to the care plan. During interview on 11/20/23 at 2:51 p.m., Nurse practitioner (NP)-A stated an awareness of a moisture related wound on R4's bottom, however did not know much about it, such as size, coloring or progression. NP-A indicated staff should be turning and repositioning in accordance to care plan and R4 was at high risk for skin breakdown and should be monitored closely. NP-A indicated it would not be appropriate for R4 to go longer go longer than 3 hours without being turned or repositioned. Braden Scale assessments and skin risk factors forms requested and not received. Policy for skin and wound management dated 11/17/23 indicates the policy is to Provide guidelines for assessing and managing wounds. 1. A pressure ulcer risk assessment (Braden Scale) will be completed per Monarch's Assessment Schedule/Grid. 2. Implement appropriate preventative skin measures. 3. Skin Evaluation and Skin Risk Factors Form is completed on admission, annually, and upon significant change.	2 905		

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2 905	Continued From page 19 4. Staff will perform routine skin inspections (with daily care). 5. Nurses are to be notified if skin changes are identified. 6. A weekly skin inspection will be completed by licensed staff. For ongoing skin issues: staff are to update provider and resident/representative as needed and update care plan as needed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/revise policies and procedures skin and wound management. The administrator or designee could educate all staff on these policies and procedures. The administrator or designee could audit to ensure all residents free from the risk of new pressure ulcer development, and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 905		