Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 17, 2025

Administrator
Cura Of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: May 1, 2025

Dear Administrator:

On June 16, 2025, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 17, 2025

Administrator
Cura Of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

Re: Reinspection Results
Event ID: D20K12

Dear Administrator:

On June 16, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 1, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

Administrator
Cura Of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

RE: CCN: 245416
Cycle Start Date: May 1, 2025

Dear Administrator:

On May 1, 2025, 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, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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 August 1, 2025 (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 November 1, 2025 (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)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245416	A. BUILDING _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF LE SUEUR	621 SOUTH 4TH STREET LE SUEUR, MN 56058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/30/25 and 5/1/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54163788C (MN00112673), H54163027C (MN00112276), and H54163027C (MN00112337) with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		6/11/25

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

Electronically Signed | 05/22/2025

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

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F 684	Continued From page 1 Based on interview and record review the facility failed to complete a comprehensive skin assessment and monitoring of impaired skin integrity for 1 of 3 residents (R1) reviewed for skin care. Findings include: R1's hospital discharge summary dated 4/24/25, identified invasive ductal carcinoma (cancer that starts in the cells lining the milk duct in the breast and breaks through the duct wall invading nearby breast tissue) had been discovered during a previous hospital stay 2/2025 and treatment had not begun yet. Current hospital stay was complicated by right breast pain with oncology follow-up 5/1/25 scheduled. Skin check identified tender, indurated (thickened/hard) right breast including the areola (pigmented area surrounding the nipple), without warmth and consistent with known breast cancer, likely lymphatic obstruction (blockage of lymph vessels which can lead to swelling). R1's face sheet dated 5/1/25, identified diagnoses of malignant neoplasm of lower outer quadrant of right breast (cancer). R1's care plan dated 4/24/25, identified two areas of concern which included potential for skin integrity impairment related to decreased mobility from baseline. Interventions included licensed nurse to observe skin weekly and turn and reposition per tissue tolerances. Alteration in comfort related to right breast cancer. Interventions included medications as ordered, non-pharmacological interventions including repositioning, massage, distraction, reposition/ambulation as tolerated and physical	F 684	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: -R1 has discharged from the facility; corrective action is no longer applicable. How the facility will identify other residents having the potential to be affected by the same deficient practice: - A review will be completed of resident impaired skin integrity to assure that appropriate monitoring and assessment is in place and being completed. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: - Re-Education will be provided to facility nursing staff regarding the need to appropriately and thoroughly document, monitor and observe skin impairments on admission, during routine weekly skin observations as well as needed for reports of pain. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: - The Director of Nursing and/or designee will conducts audits of resident skin impairments to assure appropriate monitoring, assessment and interventions are in place. Audits will be completed weekly for four weeks then monthly until the next Quality Assurance and Performance Improvement Committee at which time results will be reviewed for	

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F 684	Continued From page 2 and occupational therapy as directed. R1's Skin Evaluation dated 4/24/25, identified an initial skin evaluation with no skin impairments noted. R1's Comprehensive Skin Risk Audit dated 4/24/25, identified skin history of cancer and no changes warranted to the interventions to maintain resident's skin integrity. R1's progress note at 6:36 p.m. note identified R1 reported pain in right breast area. Progress note at 9:52 p.m., identified R1 requested pain medication for right breast pain. R1's record did not include a comprehensive assessment of R1's right breast to ascertain any changes to the location. R1's progress note dated 4/25/25, identified R1 had pain 10/10 to right breast. R1's record did not include an assessment of the right breast. R1's progress note dated 4/26/25 at 5:27 a.m., identified pain medication given for right breast pain. R1's record did not include an assessment of the right breast. R1's progress note dated 4/27/25, identified R1's pain management was not under control and R1 requested to go to the emergency department for pain management. R1's progress noted dated 4/27/25, identified as a late entry progress noted identified a hospitalist called and requested initial admission details, including pictures of R1's right breast at admission to compare how the breast appeared currently in comparison to what the breast	F 684	ongoing oversight and adjustment as necessary.	

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F 684	Continued From page 3	F 684		

appeared like at the facility. No admission photos were in R1's chart. The doctor advised the right breast was full of abscess and required a surgical procedure to drain as it was infected.

R1's progress note dated 4/28/25 at 9:07 a.m., identified a late entry for 4/24/25 that stated R1 had a small area of skin redness to right breast and the area was tender to the touch with 10/10 pain. There was no drainage to the sight and no symptoms of infection. A second note written at 1:38 p.m., identified R1 would not be returning to the facility after hospitalization.

During an interview on 5/1/25 at 1:01 p.m., nursing assistant (NA)-D stated R1's breast was a little red and tender and R1 prefer that NA-D not touch them when doing cares.

During a phone interview on 5/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated he had not looked at R1's breast and was unaware of the breast cancer.

During a phone interview on 5/1/25 at 12:50 p.m., registered nurse (RN)-C stated there were no treatment orders in the record that identified to monitor the right breast and that would be how the floor nurses would be aware of conditions to monitor on residents.

During a phone interview on 5/1/25 at 12:36 p.m., RN-A stated that the floor nurse works under the orders that are transcribed in the treatment and medication record. R1 did not have any orders for the breast cancer site and there were no progress notes or assessments in the chart about the breast cancer site either.

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F 684	Continued From page 4 During a phone interview on 5/1/25 at 9:40 a.m., family member (FM)-A stated R1's breast cancer was a newer diagnosis. The breast cancer site was visible and bright red. During a phone interview on 5/1/25 at 9:28 a.m., certified nurse practitioner (CNP)-A stated R1 had a large breast lump between six and nine o'clock on the outer right breast with redness surrounding the site. CNP-A was aware of breast cancer site and had observed it at a previous facility on 3/10/25 and did not notice anything out of the ordinary or concerning when she examined it on 4/25/25. During a phone interview on 5/1/25 at 11:31 a.m., emergency department registered nurse (EDRN)-A stated on 4/27/25, R1's breast looked like it had an obvious abscess. The breast was red, raised, warm, and had an area that was coming to a head. During an interview on 5/1/25 at 3:58 p.m., the Administrator and director of nursing (DON) were present. The DON stated there was nothing in the admission or skin assessment that documented the right breast cancer site or what it looked like. DON stated on admission he completed the admission and skin assessments and R1's breast looked like a breast that had cancer. The skin assessment did not reflect the right breast cancer. The facility Comprehensive Person-Centered Care Plan policy dated 2/2025, identified the care plan would incorporate identified problem areas and incorporate risk factors associated with identified problems and develop interventions that are targeted and meaningful to the resident.	F 684		

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F 684	Continued From page 5 When possible the interventions will address the underlying source of the problem areas and not just address symptoms or triggers. The facility policy Surveillance for Infections dated 1/2025, identified the infection preventionist (IP) would gather information by review of resident records.	F 684		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

Administrator
Cura Of Le Sueur
621 South 4th Street
Le Sueur, MN 56058

Re: State Nursing Home Licensing Orders
Event ID: D20K11

Dear Administrator:

The above facility was surveyed on April 30, 2025 through May 1, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
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
	00336	A. BUILDING: _____ B. WING _____	C 05/01/2025

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CURA OF LE SUEUR	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/30/25 and 5/1/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H54163788C (MN00112673), H54163027C (MN00112276), and H54163027C (MN00112337) with licensing orders issued at: 0830 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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	00336	A. BUILDING: _____ B. WING _____	C 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURA OF LE SUEUR	621 SOUTH 4TH STREET LE SUEUR, MN 56058

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	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 interview and record review the facility failed to complete a comprehensive skin assessment and monitoring of impaired skin integrity for 1 of 3 residents (R1) reviewed for skin care. Findings include: R1's hospital discharge summary dated 4/24/25,	2 830	Corrected.	6/11/25

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2 830	Continued From page 3 identified invasive ductal carcinoma (cancer that starts in the cells lining the milk duct in the breast and breaks through the duct wall invading nearby breast tissue) had been discovered during a previous hospital stay 2/2025 and treatment had not begun yet. Current hospital stay was complicated by right breast pain with oncology follow-up 5/1/25 scheduled. Skin check identified tender, indurated (thickened/hard) right breast including the areola (pigmented area surrounding the nipple), without warmth and consistent with known breast cancer, likely lymphatic obstruction (blockage of lymph vessels which can lead to swelling). R1's face sheet dated 5/1/25, identified diagnoses of malignant neoplasm of lower outer quadrant of right breast (cancer). R1's care plan dated 4/24/25, identified two areas of concern which included potential for skin integrity impairment related to decreased mobility from baseline. Interventions included licensed nurse to observe skin weekly and turn and reposition per tissue tolerances. Alteration in comfort related to right breast cancer. Interventions included medications as ordered, non-pharmacological interventions including repositioning, massage, distraction, reposition/ambulation as tolerated and physical and occupational therapy as directed. R1's Skin Evaluation dated 4/24/25, identified an initial skin evaluation with no skin impairments noted. R1's Comprehensive Skin Risk Audit dated 4/24/25, identified skin history of cancer and no changes warranted to the interventions to maintain resident's skin integrity.	2 830		

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2 830	Continued From page 4 R1's progress note at 6:36 p.m. note identified R1 reported pain in right breast area. Progress note at 9:52 p.m., identified R1 requested pain medication for right breast pain. R1's record did not include a comprehensive assessment of R1's right breast to ascertain any changes to the location. R1's progress note dated 4/25/25, identified R1 had pain 10/10 to right breast. R1's record did not include an assessment of the right breast. R1's progress note dated 4/26/25 at 5:27 a.m., identified pain medication given for right breast pain. R1's record did not include an assessment of the right breast. R1's progress note dated 4/27/25, identified R1's pain management was not under control and R1 requested to go to the emergency department for pain management. R1's progress noted dated 4/27/25, identified as a late entry progress noted identified a hospitalist called and requested initial admission details, including pictures of R1's right breast at admission to compare how the breast appeared currently in comparison to what the breast appeared like at the facility. No admission photos were in R1's chart. The doctor advised the right breast was full of abscess and required a surgical procedure to drain as it was infected. R1's progress note dated 4/28/25 at 9:07 a.m., identified a late entry for 4/24/25 that stated R1 had a small area of skin redness to right breast and the area was tender to the touch with 10/10 pain. There was no drainage to the sight and no symptoms of infection. A second note written at	2 830		

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2 830	Continued From page 5 1:38 p.m., identified R1 would not be returning to the facility after hospitalization. During an interview on 5/1/25 at 1:01 p.m., nursing assistant (NA)-D stated R1's breast was a little red and tender and R1 prefer that NA-D not touch them when doing cares. During a phone interview on 5/1/25 at 12:49 p.m., licensed practical nurse (LPN)-A stated he had not looked at R1's breast and was unaware of the breast cancer. During a phone interview on 5/1/25 at 12:50 p.m., registered nurse (RN)-C stated there were no treatment orders in the record that identified to monitor the right breast and that would be how the floor nurses would be aware of conditions to monitor on residents. During a phone interview on 5/1/25 at 12:36 p.m., RN-A stated that the floor nurse works under the orders that are transcribed in the treatment and medication record. R1 did not have any orders for the breast cancer site and there were no progress notes or assessments in the chart about the breast cancer site either. During a phone interview on 5/1/25 at 9:40 a.m., family member (FM)-A stated R1's breast cancer was a newer diagnosis. The breast cancer site was visible and bright red. During a phone interview on 5/1/25 at 9:28 a.m., certified nurse practitioner (CNP)-A stated R1 had a large breast lump between six and nine o'clock on the outer right breast with redness surrounding the site. CNP-A was aware of breast cancer site and had observed it at a previous facility on 3/10/25 and did not notice anything out of the	2 830		

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2 830	Continued From page 6 ordinary or concerning when she examined it on 4/25/25. During a phone interview on 5/1/25 at 11:31 a.m., emergency department registered nurse (EDRN)-A stated on 4/27/25, R1's breast looked like it had an obvious abscess. The breast was red, raised, warm, and had an area that was coming to a head. During an interview on 5/1/25 at 3:58 p.m., the Administrator and director of nursing (DON) were present. The DON stated there was nothing in the admission or skin assessment that documented the right breast cancer site or what it looked like. DON stated on admission he completed the admission and skin assessments and R1's breast looked like a breast that had cancer. The skin assessment did not reflect the right breast cancer. The facility Comprehensive Person-Centered Care Plan policy dated 2/2025, identified the care plan would incorporate identified problem areas and incorporate risk factors associated with identified problems and develop interventions that are targeted and meaningful to the resident. When possible the interventions will address the underlying source of the problem areas and not just address symptoms or triggers. The facility policy Surveillance for Infections dated 1/2025, identified the infection preventionist (IP) would gather information by review of resident records. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure	2 830		

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2 830	Continued From page 7 they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		