



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 23, 2024

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

RE: CCN: 245574
Cycle Start Date: March 4, 2024

Dear Administrator:

On April 16, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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

April 23, 2024

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: Reinspection Results
Event ID: D7B612

Dear Administrator:

On April 16, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 4, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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
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March 14, 2024

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

RE: CCN: 245574
Cycle Start Date: March 4, 2024

Dear Administrator:

On March 4, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

Sholom Home West

March 14, 2024

Page 2

- 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 June 4, 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 September 4, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by

Sholom Home West

March 14, 2024

Page 3

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/ltr_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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March 14, 2024

Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: State Nursing Home Licensing Orders
Event ID: D7B611

Dear Administrator:

The above facility was surveyed on February 29, 2024 through March 4, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Sholom Home West

March 14, 2024

Page 2

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245574	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
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NAME OF PROVIDER OR SUPPLIER SHOLOM HOME WEST	STREET ADDRESS, CITY, STATE, ZIP CODE 3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>On 2/29/24 and 3/4/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaint was reviewed: H55741283C (MN00101126) with a deficiency cited at F684.</p> <p>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.</p> <p>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.</p>	F 000		
F 684 SS=D	<p>Quality of Care CFR(s): 483.25</p> <p>§ 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 interview and record review, the facility</p>	F 684	R1 was sent to the hospital on 2/22/24	4/3/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/23/2024
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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	<p>Continued From page 1</p> <p>failed to comprehensively assess and monitor edema for 2 of 2 (R1, R3) residents reviewed with lower extremity edema.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) assessment dated 1/30/24, indicated R1 was admitted on 1/24/24 and had diagnoses including traumatic ischemia of muscle (inadequate blood supply to muscles), benign neoplasm of meninges (brain tumor), multiple sclerosis, history of COVID-19, and muscle weakness. R1 required supervisory assistance with transfers, moderate assistance with mobility in bed and standing up, and maximal assistance with lower body dressing and putting on or taking off footwear.</p> <p>R1's Admission/Readmission Full Body Observation skin assessment dated 1/24/24, noted a dry scab on R1's left outer ankle and did not note any other skin conditions on R1's legs.</p> <p>A progress note dated 1/24/24, indicated R1 had bilateral (both) lower extremity (BLE) edema (swelling caused by fluid in the body's tissues). The progress note did not identify the extent of edema.</p> <p>R1's orders included an order dated 1/24/24, to take vital signs and weights per facility protocol.</p> <p>A progress note dated 1/29/24 by a Registered Dietician (RD), indicated R1 had a usual body weight of 179 pounds (lbs.) with a current body weight of 179.4 lbs on 1/28/24, 197.4 lbs. on 1/27/24, and 183 lbs. on 1/24/24. Hospital weights prior to admission were 187 lbs. and 188 lbs. BLE edema per nursing progress notes was</p>	F 684	<p>with diagnosis of acute pancreatitis, UTI and COVID. R1 released the bed hold on 3/2/24 and discharged from the hospital to another SNF. R1 was not in the facility at time of survey.</p> <p>R3 presented with fluid filled blisters which the facility deemed were secondary to edema. On 3/6/24, R3 was seen by Dr. Dakin (Dermatologist), following biopsy results R3's fluid filled sacs (bulla) were diagnosed as bullous pemphigoid. Since diagnosed R3 has been treated with Prednisone, doxycycline, nicotinamide, atarax, triamcinolone ointment, and mupirocin ointment. R3 is being followed by both Dermatology every two weeks and AHI Wound NP Services weekly. Nursing staff to monitor bullous pemphigoid and edema daily and update provider with changes. R3 also has a diagnosis of chronic lymphedema, R3 was evaluated by the MD on 3/1/24, at that time R3 was noted to have mild to moderate edema orders included; stable on torsemide, tubigrips and R3 declined lymphedema treatment. On 3/8/24, R3 received new orders from dermatologist following biopsy results to discontinue tubigrips and treat bulla wrap with kerlix then apply ace wraps over kerlix daily. R3's edema is assessed and monitored daily. R3's weight is monitored daily.</p> <p>All residents in the facility are at risk for edema. The facility has initiated a full body assessment assessing edema of each resident in the facility. This will include review of the clinical record,</p>	

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F 684	<p>Continued From page 2</p> <p>noted with a plan to continue to monitor intakes, weights, and skin integrity.</p> <p>A progress note dated 1/31/24, indicated R1 refused a shower and skin check. It did not indicate if R1 also refused to be weighed.</p> <p>A progress note dated 2/9/24, by an RD, indicated R1's current body weight was 176.2 lbs. [on 2/7/24], resident previously noted a usual body weight of 179 lbs. but today noted she weighed 156 lbs. at home. R1 had a history of BLE edema and her intakes, weights, and skin integrity would continue to be monitored.</p> <p>A progress note dated 2/10/24, indicated R1 refused a shower, skin check, and weight check.</p> <p>A progress note dated 2/16/24, by nurse manager licensed practical nurse (LPN)-A, noted R1 had edema in both legs measured as 2+ on the left leg and 3+ on the right leg (edema that is pitting leaves a dimple after being pressed on and is measured by depth of indentation from 1+ being the shallowest to 4+ being the deepest) with three fluid filled blisters on the right leg and was not on a diuretic (medication to help reduce excessive fluid build-up). Family and the provider were updated, orders for wound dressing obtained, R1 was referred to the wound care team to be seen the following week, dietary was notified for nutritional support to promote wound healing, and it was planned to put a recliner in R1's room to promote elevation of legs.</p> <p>R1's physician orders included an order dated 2/16/24, to assess wound dressing integrity and surrounding skin daily and redress as needed, and to alert provider to unrelieved pain, negative</p>	F 684	<p>diagnosis and body audit/observation completed by a licensed nurse.</p> <p>If a resident has a diagnosis of CHF the nurse will monitor weights daily and/or per orders. If the resident experiences a weight gain the nurse will assess, monitor and update the provider as indicated.</p> <p>If a resident has a diagnosis of lymphedema and/or lower extremity edema is present, the nurse will assess the edema, initiate monitoring and update the provider as indicated.</p> <p>Facility will educate all nursing staff regarding R3's diagnosis, orders, assessment and monitoring per orders and care plan. Facility will educate nursing staff regarding:</p> <ul style="list-style-type: none"> * The need to assess for edema weekly and/or per orders, the assessment will be documented in the resident medical record. * The importance of monitoring edema for changes and documenting in the resident medical record. * The expectations of obtaining, monitoring and weighing residents with edema and CHF per orders and update provider as indicated. <p>Facility will audit seven residents weekly who present with edema, for assessment, monitoring, and documentation in the medical record for four weeks. Following the four weeks the audit will be completed</p>	

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F 684	<p>Continued From page 3</p> <p>changes in wound, or signs or symptoms of infection daily. An order dated 2/17/24 instructed to apply Tubigrips (elastic tubular compression bandage) in the morning and remove at bedtime for R1's BLE edema and to encourage elevation of BLE.</p> <p>A progress note dated 2/17/24, indicated R1's "bilateral lower legs are edematous." No further assessment or description of the edema was documented.</p> <p>A progress note dated 2/18/24, indicated R1's left leg was swollen, and the fluid blisters were oozing. No further assessment or description of the edema was documented.</p> <p>A progress note dated 2/19/24, indicated R1's left leg was oozing and R2 refused to elevate her legs at night. No further assessment or description of the edema was documented.</p> <p>A progress note dated 2/19/24 by a RD, indicated R1's current body weight was 176 lbs. [on 2/17/24] and R1 had BLE edema. No further assessment or description of the edema was noted.</p> <p>R1's care plan included a focus on potential for alteration in skin integrity with an intervention created 2/19/24 to encourage elevation of BLE due to edema.</p> <p>An Advanced Health Institute wound care note dated 2/21/24, indicated R1 had increased edema in BLE and had serous (fluid-filled) blisters were open wounds on the right leg.</p> <p>Wound Management entries created by LPN-A on</p>	F 684	<p>monthly for three months and results will be brought to QA for review.</p> <p>Date of compliance: 4/3/24</p>	

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F 684	<p>Continued From page 4</p> <p>2/21/24 detailed three right shin blisters and one left ankle ulcer but did not include assessment or description of the BLE edema.</p> <p>A progress note dated 2/22/24, indicated R1 was transferred to the hospital for a change in condition at 2:30 p.m. related to increased leg pain and abnormal vital signs per provider order.</p> <p>Vital signs recorded in the vital signs section of R1's electronic health record included:</p> <ul style="list-style-type: none"> - 183 lbs on admission on 1/24/24 - 197.4 lbs on 1/27/24 [presumed erroneous entry intended to be 179.4 lbs.] - 179.4 lbs on 1/28/24 - 179.4 lbs on 1/29/24 - 179.6 lbs on 1/30/24 - 179.4 lbs on 2/1/24 - 175.6 lbs on 2/5/24 - 176.2 lbs on 2/7/24 - 176 lbs on 2/17/24 <p>An admission vital signs flow sheet from Methodist Hospital included R1's first charted weight at the hospital as 195 lbs. on 2/23/24 at 12:36 p.m. This was 19 lbs. more than R1's last recorded weight at the facility of 176 lbs. on 2/17/24.</p> <p>In an interview on 3/4/24 at 1:07 p.m., LPN-A stated R1 had edema in her legs that was weeping (leaking fluid through the skin) which LPN-A assessed in a progress note dated 2/16/24. LPN-A stated that progress note from 2/18/24 just said R1's leg was swollen and the progress note from 2/19 just said the left leg was oozing. The notes did not include further assessment such as a 1+ to 4+ measurement of the depth of the edema. LPN-A noted R1 then</p>	F 684		

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F 684	<p>Continued From page 5</p> <p>had an initial visit with the wound care team on 2/21/24. LPN-A stated "there's not any assessment of the edema after the 16th, I can't find any." LPN-A noted that for someone with edema, her expectation would be that nurses assess the edema daily and complete a full observation by removing any dressings or clothing, checking for pitting, weeping, and redness because there could be infection. LPN-A stated to monitor edema, staff check for pitting from 1+ to 4+ and check the tension of the skin. If a resident has edema, nurses should do a full body assessment including listening to lung sounds and getting a set of vital signs. LPN-A noted for someone with edema, she would expect them to be getting weighed. LPN-A confirmed R1's last weights were on 2/5/24, 2/7/24, and 2/17/24 and R1 was not a resident whose weight was taken daily, R1 did not have congestive heart failure as a diagnosis so she was not weighed daily. LPN-A stated the first time R1's edema was noticed was on 2/16/24 and there wasn't a full assessment of the edema from then until she was seen by the wound care team on 2/21/24. LPN-A stated that based on the documentation entered after her note on 2/16/24, staff would not be able to monitor R1's edema to ascertain if it was worsening.</p> <p>R3's face sheet printed 3/5/24 indicated R3 was admitted on 11/15/23 and had diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), nutritional anemia, bullous disorder (a skin condition causing large fluid-filled blisters), erythema intertrigo (an inflammatory skin condition causing redness and rash), candidiasis (fungal infection) of skin and nails, and mild cognitive impairment.</p>	F 684		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 6</p> <p>A new admission nursing progress note dated 11/15/23, indicated R3 had 3+ BLE edema.</p> <p>R3's Physical Therapy Evaluation & Plan of Treatment dated 11/17/23, noted that R3 required maximum assist with mobility in bed and moderate assist with transfers.</p> <p>R3's new admission provider note dated 11/17/23, indicated R3 had swollen legs with lymphedema (swelling caused by build-up of fluid in tissues related to dysfunction of the body's lymphatic system) wraps as well as blisters reported by nursing staff. Assessment noted edema of both right and left lower legs (note did not identify extent of edema), blister on both ankles, a couple of open areas on the skin, and legs wet with serous drainage. R3 was noted to have lymphedema. R3's diagnoses did not include CHF at this time.</p> <p>An Initial Nutritional Assessment note dated 11/17/23 by an RD, indicated fluctuations in R3's weight were anticipated secondary to the present of 3+ BLE edema.</p> <p>R3's care plan included a problem of potential for altered cardiovascular status related to diagnoses of hypertension, atrial fibrillation (irregular heartbeat), hyperlipidemia (high cholesterol), and past medical history with an intervention dated 11/26/23 to assess and monitor for signs of cardiac decompensation, [cardiac] diet as ordered, and monitor weight and updated provider as needed.</p> <p>A provider note dated 12/7/23, indicated R3 was seen for follow up on a chest x-ray completed on</p>	F 684		

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F 684	<p>Continued From page 7</p> <p>12/1/23 due to weight gain and shortness of breath reported by facility staff. The x-ray showed a pattern of CHF with pleural effusions (fluid build-up around the lungs), took a three day course of Lasix (a diuretic), and was then started on a different diuretic, torsemide, for the ongoing edema which was improved. The plan for the lymphedema and CHF were to continue taking torsemide daily, elevate legs above heart level, and use lymphedema wraps managed by occupational therapy.</p> <p>A provider note dated 12/19/23, indicated staff encouraged R3 to elevate her legs during the day but R3 did not always comply. R3 had an order for lymphedema wraps but refused them at the time.</p> <p>A provider note dated 1/9/24, indicated R3 was seen at the request of staff for open areas on BLE. R3 had blisters on her legs last week that had opened, had lymphedema, and did not like to elevate her legs but was encouraged by staff to do so daily. The plan included daily wound care by nursing and a visit with the wound care provider later that week.</p> <p>A occupational therapy (OT) note dated 2/22/24, identified OT had been managing R3's lymphedema wraps and were assessing/monitoring edema. Note indicated OT's lymphedema treatments were put on hold because R3 required wound care and the last girth measurements of R3's legs were obtained on 1/9/24; right lower extremity was 242.3 centimeters (cm) and left lower extremity was 245.5 cm.</p> <p>In review of R3's record it was not evident R3's</p>	F 684		

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F 684	<p>Continued From page 8</p> <p>edema was consistently monitored and assessed after 1/9/24.</p> <p>An Advanced Health Institute wound care note dated 1/10/24, indicated R3 had a left shin wound secondary to lymphedema and continued to have 2+ pitting edema bilaterally.</p> <p>An Advanced Health Institute wound care note dated 2/7/24, indicated 3+ swelling on BLE and bilateral wounds secondary to lymphedema and weeping with improvement over the last week.</p> <p>An Advanced Health Institute wound care note dated 2/14/24, indicated 2+ swelling on BLE and bilateral wounds secondary to lymphedema and weeping with the edema significantly lessened over the last two weeks.</p> <p>A Comprehensive Nutritional Assessment dated 2/19/24, indicated R3 had lower extremity edema and leg wounds, but did not include further description or assessment of the edema.</p> <p>A progress note dated 2/19/24 by LPN-A, indicated R3's BLE were extremely swollen on both upper thigh and lower shin areas. It did not include further description or assessment of the edema.</p> <p>An Advanced Health Institute wound care note dated 2/21/24, indicated R3 continued to have bilateral wounds secondary to lymphedema and weeping with 2+ swelling on BLE, new blisters, and new suspicion of bullous pemphigoid (a type of skin disease that causes large fluid-filled blisters, part of a category of conditions called immuno-bullous diseases) diagnosis.</p>	F 684		

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F 684	<p>Continued From page 9</p> <p>A progress note dated 2/22/24, indicated R3 was transferred to the hospital for a change in condition related to blisters, vomiting, and diarrhea.</p> <p>A Hospital Medicine Progress Note dated 2/23/24, indicated R3 was diagnosed with immuno-bullous skin disease.</p> <p>A progress note dated 2/28/24 indicated R3 was re-admitted to the facility from the hospital.</p> <p>In an interview on 3/4/24 at 12:55 p.m., R3 stated she was not doing well because of her blisters and was recently in the hospital but didn't know why. R3 stated she did not do anything for the swelling in her legs but could see when they were more swollen. R3 did not know if staff did anything about the swelling and did not know if staff measured her legs but knew staff looked at her skin on shower days.</p> <p>In an interview on 3/4/24 at 1:07 p.m., LPN-A stated R3 had CHF, lymphedema, and the new immuno-bullous skin disease. LPN-A noted that treatment had included wound care team, occupational therapy, dietary, and referral to dermatology with treatments and interventions adjusted over the course of R3's admission and overall improvement of the edema. LPN-A stated R3 was on daily weights and her weights had been stable, LPN-A noted she wanted to keep track of weights for residents with CHF. LPN-A confirmed that a person's edema can increase without a corresponding change in weight. In regard to R3's edema, LPN-A stated it is something R3 was admitted with, there hasn't been tracking of it, and a result of the edema was the water blisters. LPN-A noted that her nursing</p>	F 684		

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F 684	<p>Continued From page 10</p> <p>staff are visually assessing R3's edema, but have not put it in progress notes.</p> <p>In an interview on 3/4/24 at 1:57 p.m., registered nurse (RN)-A stated nurses assess edema daily and document in a progress note. RN-A noted an edema assessment includes daily weights, checking the color and firmness of the skin, measuring for pitting edema from 1+ to 4+, and assessing wounds if present. RN-A stated she did not know how to assess edema if it was not pitting edema. RN-A stated nurses can tell if edema is getting worse based on weight increases, if pitting edema becomes deeper, or if the edema is visibly increased. RN-A noted that most of the time nursing staff do daily weights for residents with edema or congestive heart failure and nurses can do daily weights using nursing judgement.</p> <p>In an interview on 3/4/24 at 2:13 p.m., RN-B stated for a resident with edema, a nurse needs to look at it and know the size of the edema and that this is measured by pushing on the edema and rating it for pitting edema. RN-B stated nurses need to assess to know if the edema is getting better or worse or has changed, like if it is pitting or weeping less. RN-B stated edema should be assessed daily and assessment information put in a progress note. RN-B stated that the description of edema as swollen is not comprehensive and doesn't indicate the size of the edema because swollen can mean different sizes and doesn't provide enough information to identify change in the edema.</p> <p>In an interview on 3/4/24 at 2:35 p.m., director of nursing (DON)-A stated nurses should assess edema while providing treatments, cares, and</p>	F 684		

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F 684	<p>Continued From page 11</p> <p>services per a resident's treatment schedule or per facility policy. DON-A stated that if a resident used Tubigrips, nurses would be assessing the resident's edema when they take them on and off every day. DON-A stated that per nursing standards of professional practice, an edema assessment should include the severity of the edema, like checking the pitting of the edema; for R1 this would include lower extremity temperature and color, if the edema is pitting or not, and measurement of the severity of the pitting of the edema using the 1+ to 4+ scale. DON-A stated R1 was monitored throughout her stay but did not know where everyone documents edema assessment and had not looked through R1's whole record. DON-A stated the wound care nurse practitioner saw R1 on 2/21/24 and assessed her, but thought she was seen before then. DON-A noted that LPN-A assessed R1's edema on 2/16/24 and updated the nurse practitioner and believed the nurse practitioner should have "some kind of note or something and we just don't have it." DON-A stated it would have been helpful if LPN-A and nursing staff had documented that R3 refused assessment or why they didn't assess R3's pitting edema and nursing staff should attempt and document an assessment or attempted assessment. DON-A stated "I don't think her [R3] notes are updated. They are monitoring her, maybe not spelling out the edema, but in their [nursing staff] minds they are monitoring her."</p> <p>Additional notes for R1 and R3 not included in the electronic medical record as of 3/4/24 were requested, but none were received.</p> <p>Facility policy titled "Skin Integrity Management" dated 11/13/22, included:</p>	F 684		

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F 684	Continued From page 12 " Non-pressure skin impairment/ injury: 1. When a resident presents with an area of skin impairment and/or skin injury the nurse will do the following: - Assess the area including measurements, description of area impaired, pain, cause of the injury - Immediately initiate first aide - If the injury is related to suspected abuse or unexplainable notify the administrator immediately - Notify the nurse practitioner/ physician - Obtain a treatment order - Initiate monitoring of the area until healed - Notify the family and/or resident representative - Create an event in Matrix - Document area of concern within the resident medical record - Update care plan with interventions to prevent reoccurrence."	F 684		

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/29/24 and 3/4/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure.</p> <p>The following complaints were reviewed:</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/23/24
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2 000	<p>Continued From page 1</p> <p>H55741283C (MN00101126). Licensing order was issued at 0830.</p> <p>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.</p> <p>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,</p>	2 000		
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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to comprehensively assess and monitor edema for 2 of 2 (R1, R3) residents reviewed with lower extremity edema.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) assessment dated 1/30/24, indicated R1 was admitted on 1/24/24 and had diagnoses including traumatic ischemia of muscle (inadequate blood supply to muscles), benign neoplasm of meninges (brain tumor), multiple sclerosis, history of COVID-19, and muscle weakness. R1 required supervisory assistance with transfers, moderate</p>	2 830	corrected	4/3/24

Minnesota Department of Health

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2 830	<p>Continued From page 3</p> <p>assistance with mobility in bed and standing up, and maximal assistance with lower body dressing and putting on or taking off footwear.</p> <p>R1's Admission/Readmission Full Body Observation skin assessment dated 1/24/24, noted a dry scab on R1's left outer ankle and did not note any other skin conditions on R1's legs.</p> <p>A progress note dated 1/24/24, indicated R1 had bilateral (both) lower extremity (BLE) edema (swelling caused by fluid in the body's tissues). The progress note did not identify the extent of edema.</p> <p>R1's orders included an order dated 1/24/24, to take vital signs and weights per facility protocol.</p> <p>A progress note dated 1/29/24 by a Registered Dietician (RD), indicated R1 had a usual body weight of 179 pounds (lbs.) with a current body weight of 179.4 lbs on 1/28/24, 197.4 lbs. on 1/27/24, and 183 lbs. on 1/24/24. Hospital weights prior to admission were 187 lbs. and 188 lbs. BLE edema per nursing progress notes was noted with a plan to continue to monitor intakes, weights, and skin integrity.</p> <p>A progress note dated 1/31/24, indicated R1 refused a shower and skin check. It did not indicate if R1 also refused to be weighed.</p> <p>A progress note dated 2/9/24, by an RD, indicated R1's current body weight was 176.2 lbs. [on 2/7/24], resident previously noted a usual body weight of 179 lbs. but today noted she weighed 156 lbs. at home. R1 had a history of BLE edema and her intakes, weights, and skin integrity would continue to be monitored.</p>	2 830		
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2 830	<p>Continued From page 4</p> <p>A progress note dated 2/10/24, indicated R1 refused a shower, skin check, and weight check.</p> <p>A progress note dated 2/16/24, by nurse manager licensed practical nurse (LPN)-A, noted R1 had edema in both legs measured as 2+ on the left leg and 3+ on the right leg (edema that is pitting leaves a dimple after being pressed on and is measured by depth of indention from 1+ being the shallowest to 4+ being the deepest) with three fluid filled blisters on the right leg and was not on a diuretic (medication to help reduce excessive fluid build-up). Family and the provider were updated, orders for wound dressing obtained, R1 was referred to the wound care team to be seen the following week, dietary was notified for nutritional support to promote wound healing, and it was planned to put a recliner in R1's room to promote elevation of legs.</p> <p>R1's physician orders included an order dated 2/16/24, to assess wound dressing integrity and surrounding skin daily and redress as needed, and to alert provider to unrelieved pain, negative changes in wound, or signs or symptoms of infection daily. An order dated 2/17/24 instructed to apply Tubigrips (elastic tubular compression bandage) in the morning and remove at bedtime for R1's BLE edema and to encourage elevation of BLE.</p> <p>A progress note dated 2/17/24, indicated R1's "bilateral lower legs are edematous." No further assessment or description of the edema was documented.</p> <p>A progress note dated 2/18/24, indicated R1's left leg was swollen, and the fluid blisters were oozing. No further assessment or description of the edema was documented.</p>	2 830		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00380	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/04/2024
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2 830	<p>Continued From page 5</p> <p>A progress note dated 2/19/24, indicated R1's left leg was oozing and R2 refused to elevate her legs at night. No further assessment or description of the edema was documented.</p> <p>A progress note dated 2/19/24 by a RD, indicated R1's current body weight was 176 lbs. [on 2/17/24] and R1 had BLE edema. No further assessment or description of the edema was noted.</p> <p>R1's care plan included a focus on potential for alteration in skin integrity with an intervention created 2/19/24 to encourage elevation of BLE due to edema.</p> <p>An Advanced Health Institute wound care note dated 2/21/24, indicated R1 had increased edema in BLE and had serous (fluid-filled) blisters were open wounds on the right leg.</p> <p>Wound Management entries created by LPN-A on 2/21/24 detailed three right shin blisters and one left ankle ulcer but did not include assessment or description of the BLE edema.</p> <p>A progress note dated 2/22/24, indicated R1 was transferred to the hospital for a change in condition at 2:30 p.m. related to increased leg pain and abnormal vital signs per provider order.</p> <p>Vital signs recorded in the vital signs section of R1's electronic health record included:</p> <ul style="list-style-type: none"> - 183 lbs on admission on 1/24/24 - 197.4 lbs on 1/27/24 [presumed erroneous entry intended to be 179.4 lbs.] - 179.4 lbs on 1/28/24 - 179.4 lbs on 1/29/24 - 179.6 lbs on 1/30/24 	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 6</p> <ul style="list-style-type: none"> - 179.4 lbs on 2/1/24 - 175.6 lbs on 2/5/24 - 176.2 lbs on 2/7/24 - 176 lbs on 2/17/24 <p>An admission vital signs flow sheet from Methodist Hospital included R1's first charted weight at the hospital as 195 lbs. on 2/23/24 at 12:36 p.m. This was 19 lbs. more than R1's last recorded weight at the facility of 176 lbs. on 2/17/24.</p> <p>In an interview on 3/4/24 at 1:07 p.m., LPN-A stated R1 had edema in her legs that was weeping (leaking fluid through the skin) which LPN-A assessed in a progress note dated 2/16/24. LPN-A stated that progress note from 2/18/24 just said R1's leg was swollen and the progress note from 2/19 just said the left leg was oozing. The notes did not include further assessment such as a 1+ to 4+ measurement of the depth of the edema. LPN-A noted R1 then had an initial visit with the wound care team on 2/21/24. LPN-A stated "there's not any assessment of the edema after the 16th, I can't find any." LPN-A noted that for someone with edema, her expectation would be that nurses assess the edema daily and complete a full observation by removing any dressings or clothing, checking for pitting, weeping, and redness because there could be infection. LPN-A stated to monitor edema, staff check for pitting from 1+ to 4+ and check the tension of the skin. If a resident has edema, nurses should do a full body assessment including listening to lung sounds and getting a set of vital signs. LPN-A noted for someone with edema, she would expect them to be getting weighed. LPN-A confirmed R1's last weights were on 2/5/24, 2/7/24, and 2/17/24 and R1 was not a resident whose weight</p>	2 830		
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Minnesota Department of Health

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2 830	<p>Continued From page 7</p> <p>was taken daily, R1 did not have congestive heart failure as a diagnosis so she was not weighed daily. LPN-A stated the first time R1's edema was noticed was on 2/16/24 and there wasn't a full assessment of the edema from then until she was seen by the wound care team on 2/21/24. LPN-A stated that based on the documentation entered after her note on 2/16/24, staff would not be able to monitor R1's edema to ascertain if it was worsening.</p> <p>R3's face sheet printed 3/5/24 indicated R3 was admitted on 11/15/23 and had diagnoses including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), nutritional anemia, bullous disorder (a skin condition causing large fluid-filled blisters), erythema intertrigo (an inflammatory skin condition causing redness and rash), candidiasis (fungal infection) of skin and nails, and mild cognitive impairment.</p> <p>A new admission nursing progress note dated 11/15/23, indicated R3 had 3+ BLE edema.</p> <p>R3's Physical Therapy Evaluation & Plan of Treatment dated 11/17/23, noted that R3 required maximum assist with mobility in bed and moderate assist with transfers.</p> <p>R3's new admission provider note dated 11/17/23, indicated R3 had swollen legs with lymphedema (swelling caused by build-up of fluid in tissues related to dysfunction of the body's lymphatic system) wraps as well as blisters reported by nursing staff. Assessment noted edema of both right and left lower legs (note did not identify extent of edema), blister on both ankles, a couple of open areas on the skin, and legs wet with serous drainage. R3 was noted to</p>	2 830		
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Minnesota Department of Health

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2 830	<p>Continued From page 8</p> <p>have lymphedema. R3's diagnoses did not include CHF at this time.</p> <p>An Initial Nutritional Assessment note dated 11/17/23 by an RD, indicated fluctuations in R3's weight were anticipated secondary to the present of 3+ BLE edema.</p> <p>R3's care plan included a problem of potential for altered cardiovascular status related to diagnoses of hypertension, atrial fibrillation (irregular heartbeat), hyperlipidemia (high cholesterol), and past medical history with an intervention dated 11/26/23 to assess and monitor for signs of cardiac decompensation, [cardiac] diet as ordered, and monitor weight and updated provider as needed.</p> <p>A provider note dated 12/7/23, indicated R3 was seen for follow up on a chest x-ray completed on 12/1/23 due to weight gain and shortness of breath reported by facility staff. The x-ray showed a pattern of CHF with pleural effusions (fluid build-up around the lungs), took a three day course of Lasix (a diuretic), and was then started on a different diuretic, torsemide, for the ongoing edema which was improved. The plan for the lymphedema and CHF were to continue taking torsemide daily, elevate legs above heart level, and use lymphedema wraps managed by occupational therapy.</p> <p>A provider note dated 12/19/23, indicated staff encouraged R3 to elevate her legs during the day but R3 did not always comply. R3 had an order for lymphedema wraps but refused them at the time.</p> <p>A provider note dated 1/9/24, indicated R3 was seen at the request of staff for open areas on</p>	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 9</p> <p>BLE. R3 had blisters on her legs last week that had opened, had lymphedema, and did not like to elevate her legs but was encouraged by staff to do so daily. The plan included daily wound care by nursing and a visit with the wound care provider later that week.</p> <p>A occupational therapy (OT) note dated 2/22/24, identified OT had been managing R3's lymphedema wraps and were assessing/monitoring edema. Note indicated OT's lymphedema treatments were put on hold because R3 required wound care and the last girth measurements of R3's legs were obtained on 1/9/24; right lower extremity was 242.3 centimeters (cm) and left lower extremity was 245.5 cm.</p> <p>In review of R3's record it was not evident R3's edema was consistently monitored and assessed after 1/9/24.</p> <p>An Advanced Health Institute wound care note dated 1/10/24, indicated R3 had a left shin wound secondary to lymphedema and continued to have 2+ pitting edema bilaterally.</p> <p>An Advanced Health Institute wound care note dated 2/7/24, indicated 3+ swelling on BLE and bilateral wounds secondary to lymphedema and weeping with improvement over the last week.</p> <p>An Advanced Health Institute wound care note dated 2/14/24, indicated 2+ swelling on BLE and bilateral wounds secondary to lymphedema and weeping with the edema significantly lessened over the last two weeks.</p> <p>A Comprehensive Nutritional Assessment dated 2/19/24, indicated R3 had lower extremity edema</p>	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 10</p> <p>and leg wounds, but did not include further description or assessment of the edema.</p> <p>A progress note dated 2/19/24 by LPN-A, indicated R3's BLE were extremely swollen on both upper thigh and lower shin areas. It did not include further description or assessment of the edema.</p> <p>An Advanced Health Institute wound care note dated 2/21/24, indicated R3 continued to have bilateral wounds secondary to lymphedema and weeping with 2+ swelling on BLE, new blisters, and new suspicion of bullous pemphigoid (a type of skin disease that causes large fluid-filled blisters, part of a category of conditions called immuno-bullous diseases) diagnosis.</p> <p>A progress note dated 2/22/24, indicated R3 was transferred to the hospital for a change in condition related to blisters, vomiting, and diarrhea.</p> <p>A Hospital Medicine Progress Note dated 2/23/24, indicated R3 was diagnosed with immuno-bullous skin disease.</p> <p>A progress note dated 2/28/24 indicated R3 was re-admitted to the facility from the hospital.</p> <p>In an interview on 3/4/24 at 12:55 p.m., R3 stated she was not doing well because of her blisters and was recently in the hospital but didn't know why. R3 stated she did not do anything for the swelling in her legs but could see when they were more swollen. R3 did not know if staff did anything about the swelling and did not know if staff measured her legs but knew staff looked at her skin on shower days.</p>	2 830		
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Minnesota Department of Health

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2 830	<p>Continued From page 11</p> <p>In an interview on 3/4/24 at 1:07 p.m., LPN-A stated R3 had CHF, lymphedema, and the new immuno-bullous skin disease. LPN-A noted that treatment had included wound care team, occupational therapy, dietary, and referral to dermatology with treatments and interventions adjusted over the course of R3's admission and overall improvement of the edema. LPN-A stated R3 was on daily weights and her weights had been stable, LPN-A noted she wanted to keep track of weights for residents with CHF. LPN-A confirmed that a person's edema can increase without a corresponding change in weight. In regard to R3's edema, LPN-A stated it is something R3 was admitted with, there hasn't been tracking of it, and a result of the edema was the water blisters. LPN-A noted that her nursing staff are visually assessing R3's edema, but have not put it in progress notes.</p> <p>In an interview on 3/4/24 at 1:57 p.m., registered nurse (RN)-A stated nurses assess edema daily and document in a progress note. RN-A noted an edema assessment includes daily weights, checking the color and firmness of the skin, measuring for pitting edema from 1+ to 4+, and assessing wounds if present. RN-A stated she did not know how to assess edema if it was not pitting edema. RN-A stated nurses can tell if edema is getting worse based on weight increases, if pitting edema becomes deeper, or if the edema is visibly increased. RN-A noted that most of the time nursing staff do daily weights for residents with edema or congestive heart failure and nurses can do daily weights using nursing judgement.</p> <p>In an interview on 3/4/24 at 2:13 p.m., RN-B stated for a resident with edema, a nurse needs to look at it and know the size of the edema and</p>	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 12</p> <p>that this is measured by pushing on the edema and rating it for pitting edema. RN-B stated nurses need to assess to know if the edema is getting better or worse or has changed, like if it is pitting or weeping less. RN-B stated edema should be assessed daily and assessment information put in a progress note. RN-B stated that the description of edema as swollen is not comprehensive and doesn't indicate the size of the edema because swollen can mean different sizes and doesn't provide enough information to identify change in the edema.</p> <p>In an interview on 3/4/24 at 2:35 p.m., director of nursing (DON)-A stated nurses should assess edema while providing treatments, cares, and services per a resident's treatment schedule or per facility policy. DON-A stated that if a resident used Tubigrips, nurses would be assessing the resident's edema when they take them on and off every day. DON-A stated that per nursing standards of professional practice, an edema assessment should include the severity of the edema, like checking the pitting of the edema; for R1 this would include lower extremity temperature and color, if the edema is pitting or not, and measurement of the severity of the pitting of the edema using the 1+ to 4+ scale. DON-A stated R1 was monitored throughout her stay but did not know where everyone documents edema assessment and had not looked through R1's whole record. DON-A stated the wound care nurse practitioner saw R1 on 2/21/24 and assessed her, but thought she was seen before then. DON-A noted that LPN-A assessed R1's edema on 2/16/24 and updated the nurse practitioner and believed the nurse practitioner should have "some kind of note or something and we just don't have it." DON-A stated it would have been helpful if LPN-A and nursing staff had</p>	2 830		
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Minnesota Department of Health

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2 830	<p>Continued From page 13</p> <p>documented that R3 refused assessment or why they didn't assess R3's pitting edema and nursing staff should attempt and document an assessment or attempted assessment. DON-A stated "I don't think her [R3] notes are updated. They are monitoring her, maybe not spelling out the edema, but in their [nursing staff] minds they are monitoring her."</p> <p>Additional notes for R1 and R3 not included in the electronic medical record as of 3/4/24 were requested, but none were received.</p> <p>Facility policy titled "Skin Integrity Management" dated 11/13/22, included: " Non-pressure skin impairment/ injury: 1. When a resident presents with an area of skin impairment and/or skin injury the nurse will do the following: - Assess the area including measurements, description of area impaired, pain, cause of the injury - Immediately initiate first aide - If the injury is related to suspected abuse or unexplainable notify the administrator immediately - Notify the nurse practitioner/ physician - Obtain a treatment order - Initiate monitoring of the area until healed - Notify the family and/or resident representative - Create an event in Matrix - Document area of concern within the resident medical record - Update care plan with interventions to prevent reoccurrence."</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with edema, to assure they are</p>	2 830		
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Minnesota Department of Health

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2 830	<p>Continued From page 14</p> <p>receiving ongoing monitoring and assessment of the edema 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.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		