DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 26, 2019

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

RE: CCN: 245164
Cycle Start Date: December 18, 2019

Dear Administrator:

On December 18, 2019, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 18, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 18, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

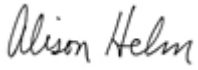
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245164	A. BUILDING _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW BRIGHTON A VILLA CENTER	**825 FIRST AVENUE NORTHWEST NEW BRIGHTON, MN 55112**

(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 12/16/19-12/18/19 an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5164152C, H5164154C The following complaint was found to not be substantiated: H5164153C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		1/22/20

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

Electronically Signed | 01/03/2020

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F 686	Continued From page 1 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed care plan interventions to prevent pressure ulcer development and when pressure ulcers did develop, failed to care plan new interventions and failed to monitor and assess the pressure ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: R1's admission Minimum Data Set (MDS) dated 11/13/19, indicated intact cognition, required extensive assistance with bed mobility and personal hygiene. R1 was at risk for pressure ulcers, but did not have a current pressure ulcer and required a pressure reducing device in wheel chair and bed, but was not on a turning and repositioning program. R1's life expectancy was less than 6 months and he was enrolled in hospice/end of life care. R1's face sheet dated 11/6/19, indicated diagnoses of throat cancer and respiratory failure. R1 did not have a Care Area Assessment (CAA) trigger for pressure ulcers, however an undated ADL (activities of daily living) CAA included no current pressure ulcer, was at risk for pressure ulcers, received assist with bed mobility, and had a pressure reducing chair cushion and mattress. The goal for R1 was to avoid complications and minimize risks and care planning would be completed for ADL's and toileting assistance. There was no indication a	F 686	1. R1 no longer resides at New Brighton, a Villa Center. 2. Residents who reside at the facility who are at risk for pressure injuries have the potential to be affected by this practice. Residents who are at risk tp develop pressure ulcers have been reassessed. Care plans and Care Delivery Guides have been updated. Any new pressure ulcer development will prompt a new care plan and interventions. Resident skin will be monitored regularly with new areas assessed by nursing. 3. Licensed Nurses and Nursing Assistants have been educated on signs of pressure, how to report findings, interventions to prevent and heal and where to document. 4. The DON/Designee to complete audits of pressure ulcer interventions and plans of care weekly for 3 weeks, then monthly for three months. The DON/Designee will bring audits to QAPI for review.	

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F 686	Continued From page 2	F 686		

care plan would be developed to prevent pressure ulcer development.

R1's care plan dated 11/7/19, included, "The resident has limited physical mobility r/t [related to] hospice. Staff were directed to use a wheel chair and ensure foot pedals were in place. The care plan did not direct staff to assist R1 with turning and re-positioning even though the MDS indicated R1 required assistance. R1's care plan included, "I have alteration in skin integrity d/t [due to] placement of neph post surgical procedure [tube placed into kidney to drain urine]." Staff were directed to record fluids drained from drain sites. The care plan failed to identify R1's risk for pressure ulcer development and failed to direct staff on how to prevent pressure ulcers from developing.

R1's progress note dated 12/3/19, included, "Did skin check on patient with hospice clinician and observed minimal redness on buttocks and small purplish area on left side of back lateral thoracic area. DON [director of nursing] also notified. Patient will remain to get repositioned every 1 hour and barrier cream placed on buttocks for comfort and prevention." However, R1's care plan did not get updated to include assisting R1 with repositioning every hour, nor applying the barrier cream. R1's medical record failed to contain any daily monitoring of the areas, or any weekly assessment of the areas to include location, size, if the skin was blanchable or not, what the surrounding tissue looked like, or any staging (pressure ulcer type/extent) of the areas. Nor was there any documentation if any further red areas had developed from 12/3/19 to 12/16/19. On 12/16/19, 13 days later, hospice

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F 686	Continued From page 3	F 686		

added a note, "Does have reddened heels, multiple red areas on spine and bony prominence's on back." The hospice note went on to indicate R1 was, "actively dying." R1's care plan was not updated to include these pressure areas either.

R1's undated nursing assistant worksheet directed staff to reposition every 2 hours. The care sheet did not direct staff on applying a barrier cream or to reposition every 1 hour as the progress note indicated on 12/3/19.

R1's progress note dated 12/12/19, included, a skin check was not completed as R1's family requested R1 not be moved. R1's progress note dated 12/13/19, included, R1 was not to be repositioned, but left comfortable, per family wishes.

R1 was observed in bed on 12/17/19, at 9:19 a.m. R1's eyes were mostly closed, but one eye fluttered softly as R1 slept. R1 did not respond or wake to a knock on the door. R1 was lying in bed on back, softly breathing with the help of a tracheostomy tube (tube that is inserted into trachea through surgical opening in neck to assist in breathing).

When interviewed on 12/17/19, at 10:40 a.m. licensed practical nurse (LPN)-A stated she had discovered the red area on R1's buttocks and purplish area on back a couple weeks ago (on 12/3/19, per progress notes). Per the progress notes, she had not measured the areas, nor checked to see if the skin was blanchable. LPN-A did not add the areas to the treatment record for monitoring or weekly assessment.

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F 686	Continued From page 4	F 686		

She had however, reported the pressure areas to the DON. LPN-A did not know what the areas currently looked like as R1's family had requested he no longer be repositioned as he was actively dying and they want to ensure he is comfortable. When asked about pressure areas, LPN-A did not mention that red areas on R1's heels or spine had developed. These areas had not been added to the treatment record for monitoring.

When interviewed on 12/18/19, at 10:53 a.m. R1's family member (F)-B stated she had been concerned about R1 not getting repositioned since admission. F-B stated a camera had been installed in R1's room and was motion activated. On 12/15/19, F-B noted the camera had activated and watched while staff were assisting R1, F-B noted, "sores all over" R1's back and spine and back of arms. At one point the camera was not activated for 12 hours leading F-B to believe R1 had not been assisted with repositioning, incontinence cares, medications or any cares during that 12 hours. Now, however, F-B was concerned with R1's comfort and no longer wanted him assisted with turning and repositioning.

When interviewed on 12/18/19, at 12:32 p.m. the assistant director of nursing (ADON) stated prior to R1's family requesting R1 not be repositioned, he was supposed to be repositioned every 2 hours. ADON was not aware R1 had any red areas on his back or spine. The direction of how often to reposition is given to the nursing assistants orally with changes, but they try and update the nurse aide care sheets for written directions. The nurse aide care sheets had not

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F 686	Continued From page 5 been updated with the 12/3/19 discovery of red areas on buttocks. The care plan did not include R1 being at risk for pressure ulcers, or actual pressure ulcers. When interviewed on 12/18/19, at 2:25 p.m. the director of nursing (DON) stated barrier cream was part of the facility standing orders. It was not documented when used as part of facility practice. If skin condition changes, the DON expected the nurse aides to alert the nurse and the nurse would document. Daily skin checks were not typically documented. Weekly skin assessments would be completed by the wound team (DON, ADON and clinical managers) if the skin was open. Since R1's skin was not open, no daily monitoring by a nurse was initiated and no weekly wound assessments had been completed.	F 686		

Electronically delivered
December 26, 2019

Administrator
New Brighton A Villa Center
825 First Avenue Northwest
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: I7HO11

Dear Administrator:

The above facility was surveyed on December 16, 2019 through December 18, 2019 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:

Karen Aldinger, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Phone: (651) 201-3794

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

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

Please feel free to call me with any questions.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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	00114	A. BUILDING: _____ B. WING _____	C 12/18/2019

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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: A complaint investigation was conducted on 12/16/19 through 12/18/19, to investigate complaint H5164152C, H5164153C, and H5164154C. As a result the following was identified: The complaints were found to be substantiated: H5164152C and H5164154C with licensing	2 000		

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2 000	Continued From page 1 orders issued. The following complaints were found to be unsubstantiated: H5164153C. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed care plan interventions to prevent pressure ulcer development and when pressure ulcers did develop, failed to care plan new interventions and failed to monitor and assess the pressure ulcers for 1 of 3 residents	2 900	Corrected	1/22/20

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2 900	Continued From page 2 (R1) reviewed for pressure ulcers. Findings include: R1's admission Minimum Data Set (MDS) dated 11/13/19, indicated intact cognition, required extensive assistance with bed mobility and personal hygiene. R1 was at risk for pressure ulcers, but did not have a current pressure ulcer and required a pressure reducing device in wheel chair and bed, but was not on a turning and repositioning program. R1's life expectancy was less than 6 months and he was enrolled in hospice/end of life care. R1's face sheet dated 11/6/19, indicated diagnoses of throat cancer and respiratory failure. R1 did not have a Care Area Assessment (CAA) trigger for pressure ulcers, however an undated ADL (activities of daily living) CAA included no current pressure ulcer, was at risk for pressure ulcers, received assist with bed mobility, and had a pressure reducing chair cushion and mattress. The goal for R1 was to avoid complications and minimize risks and care planning would be completed for ADL's and toileting assistance. There was no indication a care plan would be developed to prevent pressure ulcer development. R1's care plan dated 11/7/19, included, "The resident has limited physical mobility r/t [related to] hospice. Staff were directed to use a wheel chair and ensure foot pedals were in place. The care plan did not direct staff to assist R1 with turning and re-positioning even though the MDS indicated R1 required assistance. R1's care plan included, "I have alteration in skin integrity d/t [due to] placement of neph post surgical procedure [tube placed into kidney to drain urine]." Staff were directed to record fluids	2 900		

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	00114	A. BUILDING: _____ B. WING _____	C 12/18/2019

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2 900	Continued From page 3	2 900		

drained from drain sites. The care plan failed to identify R1's risk for pressure ulcer development and failed to direct staff on how to prevent pressure ulcers from developing.

R1's progress note dated 12/3/19, included, "Did skin check on patient with hospice clinician and observed minimal redness on buttocks and small purplish area on left side of back lateral thoracic area. DON [director of nursing] also notified. Patient will remain to get repositioned every 1 hour and barrier cream placed on buttocks for comfort and prevention." However, R1's care plan did not get updated to include assisting R1 with repositioning every hour, nor applying the barrier cream. R1's medical record failed to contain any daily monitoring of the areas, or any weekly assessment of the areas to include location, size, if the skin was blanchable or not, what the surrounding tissue looked like, or any staging (pressure ulcer type/extent) of the areas. Nor was there any documentation if any further red areas had developed from 12/3/19 to 12/16/19. On 12/16/19, 13 days later, hospice added a note, "Does have reddened heels, multiple red areas on spine and bony prominence's on back." The hospice note went on to indicate R1 was, "actively dying." R1's care plan was not updated to include these pressure areas either.

R1's undated nursing assistant worksheet directed staff to reposition every 2 hours. The care sheet did not direct staff on applying a barrier cream or to reposition every 1 hour as the progress note indicated on 12/3/19.

R1's progress note dated 12/12/19, included, a skin check was not completed as R1's family

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2 900	Continued From page 4 requested R1 not be moved. R1's progress note dated 12/13/19, included, R1 was not to be repositioned, but left comfortable, per family wishes. R1 was observed in bed on 12/17/19, at 9:19 a.m. R1's eyes were mostly closed, but one eye fluttered softly as R1 slept. R1 did not respond or wake to a knock on the door. R1 was lying in bed on back, softly breathing with the help of a tracheostomy tube (tube that is inserted into trachea through surgical opening in neck to assist in breathing). When interviewed on 12/17/19, at 10:40 a.m. licensed practical nurse (LPN)-A stated she had discovered the red area on R1's buttocks and purplish area on back a couple weeks ago (on 12/3/19, per progress notes). Per the progress notes, she had not measured the areas, nor checked to see if the skin was blanchable. LPN-A did not add the areas to the treatment record for monitoring or weekly assessment. She had however, reported the pressure areas to the DON. LPN-A did not know what the areas currently looked like as R1's family had requested he no longer be repositioned as he was actively dying and they want to ensure he is comfortable. When asked about pressure areas, LPN-A did not mention that red areas on R1's heels or spine had developed. These areas had not been added to the treatment record for monitoring. When interviewed on 12/18/19, at 10:53 a.m. R1's family member (F)-B stated she had been concerned about R1 not getting repositioned since admission. F-B stated a camera had been installed in R1's room and was motion activated.	2 900		

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2 900	Continued From page 5 On 12/15/19, F-B noted the camera had activated and watched while staff were assisting R1, F-B noted, "sores all over" R1's back and spine and back of arms. At one point the camera was not activated for 12 hours leading F-B to believe R1 had not been assisted with repositioning, incontinence cares, medications or any cares during that 12 hours. Now, however, F-B was concerned with R1's comfort and no longer wanted him assisted with turning and repositioning. When interviewed on 12/18/19, at 12:32 p.m. the assistant director of nursing (ADON) stated prior to R1's family requesting R1 not be repositioned, he was supposed to be repositioned every 2 hours. ADON was not aware R1 had any red areas on his back or spine. The direction of how often to reposition is given to the nursing assistants orally with changes, but they try and update the nurse aide care sheets for written directions. The nurse aide care sheets had not been updated with the 12/3/19 discovery of red areas on buttocks. The care plan did not include R1 being at risk for pressure ulcers, or actual pressure ulcers. When interviewed on 12/18/19, at 2:25 p.m. the director of nursing (DON) stated barrier cream was part of the facility standing orders. It was not documented when used as part of facility practice. If skin condition changes, the DON expected the nurse aides to alert the nurse and the nurse would document. Daily skin checks were not typically documented. Weekly skin assessments would be completed by the wound team (DON, ADON and clinical managers) if the skin was open. Since R1's skin was not open, no daily monitoring by a nurse was initiated and no	2 900		

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2 900	Continued From page 6 weekly wound assessments had been completed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review policies and procedures related to pressure ulcer assessment, care and treatment and ensure facility staff are educated. The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. The DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		