Electronically delivered
August 3, 2020

Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: August 3, 2020

Dear Administrator:

On August 3, 2020, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
June 28, 2020

Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

RE: CCN: 245300
Cycle Start Date: June 12, 2020

Dear Administrator:

On June 11, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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
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 Mobile: (320) 249-2805

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 September 12, 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 December 12, 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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

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F 000	INITIAL COMMENTS On June 11 and 12, 2020, abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5300039C. Deficiencies issued at F580, F660, and F686. 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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		7/17/20

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

Electronically Signed | 07/08/2020

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F 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	The policy □Change in Condition□ was	

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F 580	Continued From page 2 facility failed to ensure the physician and guardian were notified of the presence of a skin tear on the buttocks for 1 of 3 residents (R1) reviewed for discharge. Findings include: R1's interim payment assessment Minimum Data Set (MDS) dated 5/7/20, noted R1 had moderate cognitive impairment and diagnoses of medically complex condition and pneumonia. R1 did not have any skin tears. R1's progress notes, dated 5/26/20, included, "New laceration noted on patient's coccyx during dressing change." The progress notes did not reveal any evidence R1's physician or guardian were notified of the skin laceration. R1's skin integrity events-skin tear/laceration, dated 5/27/20, included R1 had a, "Skin tear observed on right buttock near intergluteal cleft (1.5 cm [centimeters] x 1 cm approximately." R1 was noted to be experiencing pain at a "5" on a scale of 0 (no pain) to 10 (excruciating pain), indicating moderate pain. R1 was provided with analgesic (pain reliever) and topical ointment. Under notifications, there was a "No" indicated for "Attending Faxed", "Physician Notified", "Resident Representative Notified", and "Care Plan Reviewed." R1's discharge orders, dated 5/27/20, included no orders related to a skin tear on right buttock. R1's discharge nurse practitioner progress note, dated 5/27/20, revealed no information related to a skin tear on R1's right buttocks. On 6/12/20, at 3:52 p.m. the registered nurse and	F 580	reviewed and remains appropriate. R1 has since discharged the facility. Licensed nursing staff reviewed all residents with current skin conditions to ensure proper notifications with change in condition have been completed, as well as ensure appropriate treatment and care plan interventions are in place. Nursing staff will be educated on the Change in Condition policy including appropriate notifications required for noted change in condition of a resident. This education will occur on July 14th and 15th, 2020. DON or designee will ensure and monitor compliance. Audits of notifications of residents with noted change in condition will be completed twice weekly for 2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 580	Continued From page 3 unit manager (RN)-B reported she instructed the nurse who discovered the wound on the bottom to notify the physician and guardian of the skin tear. RN-B reported the nurse was not aware the physician and guardian needed to be notified of new skin tears on the bottom. The change in condition policy, undated, directed staff, "When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nurse associate consults with the attending provider and notify the resident/resident representative."	F 580		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident	F 661		7/17/20

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F 661	Continued From page 4 and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the presence of an open area of skin and care instructions for the wound were included in the discharge summary and plan for 1 of 3 residents (R1) reviewed for discharge. Findings include: R1's admission Minimum Data Set dated 4/18/20, included moderate cognitive impairment and diagnoses including wound infection, stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling,) and an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar,) and moisture associated skin damage. R1 required extensive to total assistance with most activities of daily living. R1's progress notes, dated 5/26/20, included,"New laceration noted on patient's coccyx during dressing change." R1's progress notes, dated 5/27/20, revealed R1's family guardian (F)-A, picked up R1 for transport to	F 661	The policy □Discharge Planning□ was reviewed and deemed appropriate. R1 has since discharged the facility. Licensed nursing staff have reviewed all residents with anticipated discharges to ensure the Discharge Plan of Care is completed to include all relevant care plan components. Nursing staff will be educated on the Discharge Planning policy, completion of the discharge plan of care observation, and requirement to send discharge plan of care and physician orders to admitting facility/location. Education will occur on July 14th and 15th, 2020. DON or designee will ensure and monitor compliance. Audits of the Discharge Plan of Care observation will be completed up to 2 per week depending on discharges, then weekly x2 weeks, and then 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 661	Continued From page 5	F 661		

discharge to a group home. The progress notes did not reveal any evidence R1's physician or guardian were notified of the new wound.

R1's skin integrity events-skin tear/laceration, dated 5/27/20, noted R1 had a, "Skin tear observed on right buttock near intergluteal cleft (1.5 cm [centimeters] x 1 cm approximately." R1 was noted to be experiencing pain at a "5" on a scale of 0 (no pain) to 10 (excruciating pain), indicating moderate pain. R1 was provided with analgesic (pain reliever) and topical ointment. Under notifications, there was a, "No" indicated for "Attending Faxed," "Physician Notified," "Resident Representative Notified," and, "Care Plan Reviewed."

R1's discharge paperwork, including a discharge plan of care, dated 5/27/20, noted no directions related to R1's wound to his buttocks. Under the section for, "Wound Care/Treatments" there was no information related to wounds or skin issues. R1's discharge orders, dated 5/27/20, noted no orders related to a skin tear on right buttock. R1's discharge nurse practitioner progress note, dated 5/27/20, noted no direction related to a skin tear on R1's right buttocks. R1 was discharged to a group home.

On 6/11/20, at 12:43 p.m. a director from the group home was interviewed via phone. The director noted R1 arrived at the group home with a 2.5 inch by 0.5 inch open wound on his buttocks and was in pain. The staff at the group home were not notified by the nursing home of the open area and discovered it a few hours after R1 arrived. The nursing home had not provided any information regarding this wound.

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F 661	Continued From page 6 On 6/12/20, at 3:52 p.m. the registered nurse and unit manager (RN)-B reported she instructed the nurse who discovered the wound on the bottom to notify the physician for instructions and provide instructions to the group home and guardian. RN-B reported she did not find evidence the physician was consulted for care instructions regarding the skin tear or the group home or guardian provided with written instructions on care for R1's new wound. The discharge planning policy, undated, directed staff, "Information provided to the receiving provider must include: d. All special instructions or precautions for ongoing care if appropriate. e. Comprehensive care plan goals. f. All other necessary information including a copy of the discharge summary."	F 661		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 686	The policy □Prevention and Treatment of	7/17/20

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F 686	Continued From page 7 review, the facility failed to follow care planned interventions to heal current pressure ulcers and prevent new pressure ulcers from forming for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R3's admission Minimum Data Set dated 4/17/20, included cognitively intact, did not reject cares, required extensive assistance with bed mobility and toileting, diagnoses included cancer and diabetes, was at risk for developing pressure ulcers and had a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) which was present upon admission. R3's Care Area Assessment Worksheet (CAA) dated 4/23/20, noted that R3 was at risk of developing pressure ulcers, and did have a stage II pressure ulcer on the right buttock from admission. R3 was also noted to have excoriated skin due to frequent incontinent, loose stools. R3 had a decline in function and self care skills with diagnosis of cancer, malnutrition, dehydration, diabetes, and Clostridium difficile (bacterial infection of the colon) colitis. R3's pressure ulcer care plan last updated 6/12/20, noted pressure areas to sacrum/coccyx and right ear. Interventions included repositioning every two hours and as needed with one or two staff. If resident refuses repositioning/brief check to re-approach within 30 minutes. The care sheet carried by nursing assistants, dated 6/10/20, required staff to reposition R3 every two hours and as needed due to the open area to buttocks	F 686	Skin Breakdown was reviewed and remains appropriate. R3 has since expired. Licensed nursing staff reviewed all residents deemed At Risk for skin breakdown. Care plan, treatment orders, current interventions, care sheets, and progress notes of all At Risk residents were reviewed and updated as deemed appropriate. Nursing staff will be educated on the policy Prevention and Treatment of Skin Breakdown and how to identify who needs repositioning and when to re-approach after resident refusal of repositioning. This education will occur July 14th and 15th, 2020. DON or designee will ensure and monitor compliance. Audits of residents on repositioning schedules will be completed 3 times per week x2 weeks, weekly x2 weeks, and 3 times per month x2 months. Audits will be presented and reviewed at Quality Council, who will recommend changes and on-going monitoring/auditing after analysis.	

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F 686	Continued From page 8	F 686		

and right ear, and to use pillows to offload.

On 6/11/20, at 12:18 p.m. R3 was observed in bed, asleep. R3 laid on an air mattress, and the head of the bed was raised approximately 30 degrees. R3 was positioned on her right side.

On 6/11/20, at 12:22 p.m. nursing assistant (NA)-A stated knowing how to provide care to the residents because of the care sheet, which was printed weekly, or if there were changes. the care sheet dated 6/10/20, required staff to reposition R3 every two hours, and as needed, with assist of one to two staff. The care sheet also noted R3 had an open area to the buttocks and right ear.

On 6/11/20, at 2:11 p.m. NA-A entered R3's room to offer a snack. At 2:13 p.m. R3 was observed in bed and still on her right side. R3 stated she was comfortable at the moment, with no pain. R3 stated the staff do move her from side to side usually every couple hours or so, and thought they had last repositioned her about an hour and a half ago or so. R3 described having a pressure ulcer on her bottom that had improved, but then said another little one had opened up nearby. R3 also had a, "little one" on her ear, but stated it did not bother her at all, and staff were putting cream on it. R3 had no concerns with how staff were caring for her skin. At this time, R3 remained on her right side without repositioning since continuous observation started at 12:18 p.m.

On 6/11/20, at 2:47 p.m. physical therapist (PT)-C was observed checking in with R3, and stated, "I am kind of making the rounds doing strengthening and walking, I take it you're not up for it?" R3 responded that she was not up for walking, and PT-C left the room. At 2:48 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245300	A. BUILDING _____ B. WING _____	C 06/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - WHITE BEAR LAKE	**1900 WEBBER STREET WHITE BEAR LAKE, MN 55110**

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PT-C explained having a list of residents to check in with, who had previously been on therapy and discharged with walking programs. PT-C stated he knew R3 was not doing very well, and would not want to walk.

On 6/11/20, at 2:55 p.m. NA-A was asked how often R3 got repositioned. NA-A stated R3 will call staff to be moved, but explained staff also repositioned every two hours. NA-A described always repositioning R3 at 7:00 a.m. right when NA-A arrived to work, again at 9:00 a.m., and then again right around 11:00 a.m. when lunch was served, because R3 wanted to lay on her right side to eat. When asked whether 11:00 a.m. was the last time R3 was repositioned, NA-A stated she checked in on R3 about 1:00 p.m. after her break to see if she needed anything, and if she could reposition R3. NA-A said R3 did not want to be repositioned at that time, but maybe later. At this time licensed practical nurse (LPN)-A stated she thought NA-A checked in with R3 after her break, which was closer to 1:30 p.m. NA-A planned to check in with R3 about repositioning again before the end of the day shift. NA-A stated sometimes R3 calls for help with repositioning when she uncomfortable, and stated it was really up to R3 as sometimes she was wanting to move, and other times not. LPN-A confirmed R3 had one pressure ulcer on the coccyx that closed up, and mentioned another new, "tiny slit" had opened just near the healed area. LPN-A stated R3 was dealing with some difficult recent medical news, and thought that refusing care at times was R3's way of dealing with the news. At 3:01 p.m. NA-A left the unit at the end of the shift, without re-approaching R3 for repositioning as planned.

On 6/11/20, at 3:11 p.m. NA-B was working the

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evening shift, and asked how staff from the day shift passed important information onto the evening shift. NA-B stated she usually talked to a day shift NA if they had time to see what was new, and start taking vitals right away. NA-B was aware that a couple residents, including R3, usually stayed in bed. NA-B said R3 was good at telling staff if she wanted to be repositioned. When asked whether R3 was supposed to be repositioned at certain times, NA-B stated she tried to let R3 call and tell her when she wanted to be repositioned, because NA-B did not want to bother R3. NA-B stated staff tried to keep a pillow behind R3 at least. At 3:22 p.m. when asked what time R3 was last repositioned, NA-B stated she did not know when R3 had last been repositioned. NA-B confirmed that staff did not write that down, and any information about repositioning would be by word of mouth.

On 6/11/20, at 3:47 p.m. R3 was observed in bed. When asked if R3 had been repositioned recently, she responded, "not yet." R3's legs were still tilted on the right side, but it looked as though she had rolled onto her back a little bit, as her head was more flat on the pillow.

On 6/11/20 at 3:58 p.m. LPN-B stated if residents refused repositioning, she would go back in to re-approach and try again in 15 or 30 minutes. LPN-B stated checking in with the resident to encourage repositioning was another ball that staff had to try to keep in the air. LPN-B understood that R3 had gone on hospice recently, and was dealing with a lot, and should have some control over what care she wanted.

On 6/11/20, at 4:05 p.m. NA-B exited R3's room, and stated R3 had agreed to be repositioned.

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NA-B described moving R3 from her right side, to laying on her back on a pillow per resident preference. This was over 4 hours since R3 had been assisted to reposition.

On 6/11/20, at 4:11 p.m. registered nurse (RN)-A stated the nurse managers were currently monitoring wounds during weekly wound rounds. RN-A stated when R3 first admitted to the facility, she had a stage II pressure ulcer on her buttocks. A few weeks ago R3 was still walking, and staff were still treating the stage II wound she admitted with. RN-A stated in the past two weeks, R3 had declined according to the unit staff. RN-A stated R3 had been much more incontinent lately, and was not walking like she used to. RN-A was working on a MDS assessment due to the significant change. RN-A explained that the original stage II ulcer on the bottom had closed up earlier that week, but said now today during wound care before lunch, RN-A had seen a new open are that was 1 centimeter (cm) by 1 cm. RN-A described the entire sacral area as purple in color, and said the new open area could be due to shearing or could be due to pressure. RN-A was working on updating the care plan due to the changes, and educated R3 about the importance of repositioning, and telling the staff if R3 thought she was wet. RN-A stated the expectation was for staff to offer repositioning at least every two hours. If R3 refused repositioning, RN-A expected staff to check in within maybe 15 or 30 minutes. RN-A expressed not wanting R3 to feel staff were disrespecting her choices, but wanted staff to re-approach before another two hours had passed. RN-A planned to update the care sheet to guide nursing assistants with when to re-approach if R3 refused repositioning.

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The Resident Census document in the electronic medical record showed R3 was admitted to the transitional care unit on 4/10/20, and moved to her current long term care (LTC) unit on 5/26/20.

A Skin Integrity Event originally dated 4/10/20, noted R3 admitted with a stage II pressure ulcer on the right buttock, and that this area closed on 6/8/20. Skin Integrity Event dated 5/27/20, noted R3 had acquired a stage II pressure ulcer just above the coccyx. Skin Integrity Event dated 6/8/20 noted a stage II pressure ulcer to the right ear that was 0.2 cm by 0.1 cm.

A progress note dated 5/27/20, described the open area as 0.3 cm by 0.4 cm with 0.1 cm depth at the time it was discovered. In a progress note dated 5/28/20, the resident reported a history of skin breakdown in this area, with staff noting that R3 had spent almost all her time in bed since moving to her current unit. A progress note from 6/11/20 noted the pressure ulcer from admit on the buttock had resolved, but the new area on the sacrum now measured 1 cm by 1 cm, with depth of less than 0.1 cm. Staff reported resident sometimes declined brief changes or repositioning, and R3 was noted to have significant functional decline and increased incontinence since transfer to the LTC unit. R3 was on hospice with additional decline anticipated. Care sheet and care plan was updated to ensure repositioning every two hours, and re-approaching within 30 minutes if R3 declined.

Requested a policy or procedure regarding re-approaching after a resident declined care planned interventions. On 6/12/20, at 12:16 p.m. the director of nursing (DON) sent an email and

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wrote that they did not have a policy specific to timing of staff re-approach, but said the stance would be to include the resident in the conversation of what was an acceptable plan for them and work on the care plan together, rather than making that decision without resident input. DON mentioned that the care plan was updated to include staff re-approaching after 30 minutes of refusal. The DON clarified it was a fine line of continuously upsetting or bothering residents with re-approach, versus abiding by their wishes and letting them be. The goal was for R3 to be comfortable, and staff planned to check in with R3 in the next week to see how things were going with the plan to re-approach after 30 minutes of refusal.

The Prevention and Treatment of Skin Breakdown policy, copyright 2018, defined a stage II pressure injury as partial thickness skin loss with exposed dermis. These injuries commonly result from adverse microclimate and shear on the skin over the pelvis. The policy noted staff should evaluate current pressure reduction interventions and revise resident centered care plan, re-evaluating as appropriate, and educate the resident on the pressure injury and care plan interventions.

Electronically delivered
June 28, 2020

Administrator
Cerenity Care Center - White Bear Lake
1900 Webber Street
White Bear Lake, MN 55110

Re: State Nursing Home Licensing Orders
Event ID: QC9811

Dear Administrator:

The above facility was surveyed on June 11, 2020 through June 12, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Karen Aldinger, Unit Supervisor
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 Mobile: (320) 249-2805

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00923	A. BUILDING: _____ B. WING _____	C 06/12/2020

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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 June 11 and 12, 2020, to investigate complaint H5300039C. As a result the following was identified: The complaint was found to be substantiated with licensing orders issued.	2 000		

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2 000	Continued From page 1 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. 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 surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm 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.	2 000		

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2 000	Continued From 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to	2 265		7/17/20

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2 265	Continued From page 3 begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and guardian were notified of the presence of a skin tear on the buttocks for 1 of 3 residents (R1) reviewed for discharge. Findings include: R1's interim payment assessment Minimum Data Set (MDS) dated 5/7/20, noted R1 had moderate cognitive impairment and diagnoses of medically complex condition and pneumonia. R1 did not have any skin tears. R1's progress notes, dated 5/26/20, included, "New laceration noted on patient's coccyx during dressing change." The progress notes did not reveal any evidence R1's physician or guardian were notified of the skin laceration. R1's skin integrity events-skin tear/laceration, dated 5/27/20, included R1 had a, "Skin tear observed on right buttock near intergluteal cleft (1.5 cm [centimeters] x 1 cm approximately." R1 was noted to be experiencing pain at a "5" on a scale of 0 (no pain) to 10 (excruciating pain), indicating moderate pain. R1 was provided with analgesic (pain reliever) and topical ointment. Under notifications, there was a "No" indicated for "Attending Faxed", "Physician Notified", "Resident	2 265	Corrected	

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2 265	Continued From page 4 Representative Notified", and "Care Plan Reviewed." R1's discharge orders, dated 5/27/20, included no orders related to a skin tear on right buttock. R1's discharge nurse practitioner progress note, dated 5/27/20, revealed no information related to a skin tear on R1's right buttocks. On 6/12/20, at 3:52 p.m. the registered nurse and unit manager (RN)-B reported she instructed the nurse who discovered the wound on the bottom to notify the physician and guardian of the skin tear. RN-B reported the nurse was not aware the physician and guardian needed to be notified of new skin tears on the bottom. The change in condition policy, undated, directed staff, "When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nurse associate consults with the attending provider and notify the resident/resident representative." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise as needed the policy and procedure for notification of change in condition to physician and resident/ resident representative. The DON or designee could educate all staff on ensuring the physician and resident/resident representative are notified of resident changes in condition. The DON or designee could audit for compliance and report results of audit to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one	2 265		

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2 265	Continued From page 5 (21) days.	2 265		
2 690	MN Rule 4658.0465 Subp. 3 Transfer, Discharge, and Death Subp. 3. Transfer or discharge to another facility. When a resident is transferred or discharged to another health care facility or program, the nursing home must send the discharge summary compiled according to subpart 2, and pertinent information about the resident's immediate care and sufficient information to ensure continuity of care prior to or at the time of the transfer or discharge to the other health care facility or program. Additional information not necessary for the resident's immediate care may be sent to the new health care facility or program at the time of or after the transfer or discharge. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the presence of an open area of skin and care instructions for the wound were included in the discharge summary and plan for 1 of 3 residents (R1) reviewed for discharge. Findings include: R1's admission Minimum Data Set dated 4/18/20, included moderate cognitive impairment and diagnoses including wound infection, stage 3 pressure ulcer (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling,) and an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue	2 690	Corrected	7/17/20

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2 690	Continued From page 6 damage within the ulcer cannot be confirmed because it is obscured by slough or eschar,) and moisture associated skin damage. R1 required extensive to total assistance with most activities of daily living. R1's progress notes, dated 5/26/20, included,"New laceration noted on patient's coccyx during dressing change." R1's progress notes, dated 5/27/20, revealed R1's family guardian (F)-A, picked up R1 for transport to discharge to a group home. The progress notes did not reveal any evidence R1's physician or guardian were notified of the new wound. R1's skin integrity events-skin tear/laceration, dated 5/27/20, noted R1 had a, "Skin tear observed on right buttock near intergluteal cleft (1.5 cm [centimeters] x 1 cm approximately." R1 was noted to be experiencing pain at a "5" on a scale of 0 (no pain) to 10 (excruciating pain), indicating moderate pain. R1 was provided with analgesic (pain reliever) and topical ointment. Under notifications, there was a, "No" indicated for "Attending Faxed," "Physician Notified," "Resident Representative Notified," and, "Care Plan Reviewed." R1's discharge paperwork, including a discharge plan of care, dated 5/27/20, noted no directions related to R1's wound to his buttocks. Under the section for, "Wound Care/Treatments" there was no information related to wounds or skin issues. R1's discharge orders, dated 5/27/20, noted no orders related to a skin tear on right buttock. R1's discharge nurse practitioner progress note, dated 5/27/20, noted no direction related to a skin tear on R1's right buttocks. R1 was discharged to a group home.	2 690		

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2 690	Continued From page 7 On 6/11/20, at 12:43 p.m. a director from the group home was interviewed via phone. The director noted R1 arrived at the group home with a 2.5 inch by 0.5 inch open wound on his buttocks and was in pain. The staff at the group home were not notified by the nursing home of the open area and discovered it a few hours after R1 arrived. The nursing home had not provided any information regarding this wound. On 6/12/20, at 3:52 p.m. the registered nurse and unit manager (RN)-B reported she instructed the nurse who discovered the wound on the bottom to notify the physician for instructions and provide instructions to the group home and guardian. RN-B reported she did not find evidence the physician was consulted for care instructions regarding the skin tear or the group home or guardian provided with written instructions on care for R1's new wound. The discharge planning policy, undated, directed staff, "Information provided to the receiving provider must include: d. All special instructions or precautions for ongoing care if appropriate. e. Comprehensive care plan goals. f. All other necessary information including a copy of the discharge summary." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise as needed the policy and procedure for discharge summary and discharge care plan. The DON or designee could educate all staff on ensuring the discharge summary and discharge care plan includes all the information and instruction necessary for continuity of care for discharged residents. The DON or designee could audit for compliance and report results of audit to the quality assurance committee.	2 690		

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2 690	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 690		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow care planned interventions to heal current pressure ulcers and prevent new pressure ulcers from forming for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R3's admission Minimum Data Set dated 4/17/20, included cognitively intact, did not reject cares, required extensive assistance with bed mobility and toileting, diagnoses included cancer and diabetes, was at risk for developing pressure ulcers and had a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) which was present upon admission.	2 905	Corrected	7/17/20

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2 905	Continued From page 9 R3's Care Area Assessment Worksheet (CAA) dated 4/23/20, noted that R3 was at risk of developing pressure ulcers, and did have a stage II pressure ulcer on the right buttock from admission. R3 was also noted to have excoriated skin due to frequent incontinent, loose stools. R3 had a decline in function and self care skills with diagnosis of cancer, malnutrition, dehydration, diabetes, and Clostridium difficile (bacterial infection of the colon) colitis. R3's pressure ulcer care plan last updated 6/12/20, noted pressure areas to sacrum/coccyx and right ear. Interventions included repositioning every two hours and as needed with one or two staff. If resident refuses repositioning/brief check to re-approach within 30 minutes. The care sheet carried by nursing assistants, dated 6/10/20, required staff to reposition R3 every two hours and as needed due to the open area to buttocks and right ear, and to use pillows to offload. On 6/11/20, at 12:18 p.m. R3 was observed in bed, asleep. R3 laid on an air mattress, and the head of the bed was raised approximately 30 degrees. R3 was positioned on her right side. On 6/11/20, at 12:22 p.m. nursing assistant (NA)-A stated knowing how to provide care to the residents because of the care sheet, which was printed weekly, or if there were changes. the care sheet dated 6/10/20, required staff to reposition R3 every two hours, and as needed, with assist of one to two staff. The care sheet also noted R3 had an open area to the buttocks and right ear. On 6/11/20, at 2:11 p.m. NA-A entered R3's room to offer a snack. At 2:13 p.m. R3 was observed in bed and still on her right side. R3 stated she was comfortable at the moment, with no pain. R3	2 905		

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2 905	Continued From page 10	2 905		

stated the staff do move her from side to side usually every couple hours or so, and thought they had last repositioned her about an hour and a half ago or so. R3 described having a pressure ulcer on her bottom that had improved, but then said another little one had opened up nearby. R3 also had a, "little one" on her ear, but stated it did not bother her at all, and staff were putting cream on it. R3 had no concerns with how staff were caring for her skin. At this time, R3 remained on her right side without repositioning since continuous observation started at 12:18 p.m.

On 6/11/20, at 2:47 p.m. physical therapist (PT)-C was observed checking in with R3, and stated, "I am kind of making the rounds doing strengthening and walking, I take it you're not up for it?" R3 responded that she was not up for walking, and PT-C left the room. At 2:48 p.m. PT-C explained having a list of residents to check in with, who had previously been on therapy and discharged with walking programs. PT-C stated he knew R3 was not doing very well, and would not want to walk.

On 6/11/20, at 2:55 p.m. NA-A was asked how often R3 got repositioned. NA-A stated R3 will call staff to be moved, but explained staff also repositioned every two hours. NA-A described always repositioning R3 at 7:00 a.m. right when NA-A arrived to work, again at 9:00 a.m., and then again right around 11:00 a.m. when lunch was served, because R3 wanted to lay on her right side to eat. When asked whether 11:00 a.m. was the last time R3 was repositioned, NA-A stated she checked in on R3 about 1:00 p.m. after her break to see if she needed anything, and if she could reposition R3. NA-A said R3 did not want to be repositioned at that time, but maybe later. At this time licensed practical nurse (LPN)-A

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2 905	Continued From page 11	2 905		

stated she thought NA-A checked in with R3 after her break, which was closer to 1:30 p.m. NA-A planned to check in with R3 about repositioning again before the end of the day shift. NA-A stated sometimes R3 calls for help with repositioning when she uncomfortable, and stated it was really up to R3 as sometimes she was wanting to move, and other times not. LPN-A confirmed R3 had one pressure ulcer on the coccyx that closed up, and mentioned another new, "tiny slit" had opened just near the healed area. LPN-A stated R3 was dealing with some difficult recent medical news, and thought that refusing care at times was R3's way of dealing with the news. At 3:01 p.m. NA-A left the unit at the end of the shift, without re-approaching R3 for repositioning as planned.

On 6/11/20, at 3:11 p.m. NA-B was working the evening shift, and asked how staff from the day shift passed important information onto the evening shift. NA-B stated she usually talked to a day shift NA if they had time to see what was new, and start taking vitals right away. NA-B was aware that a couple residents, including R3, usually stayed in bed. NA-B said R3 was good at telling staff if she wanted to be repositioned. When asked whether R3 was supposed to be repositioned at certain times, NA-B stated she tried to let R3 call and tell her when she wanted to be repositioned, because NA-B did not want to bother R3. NA-B stated staff tried to keep a pillow behind R3 at least. At 3:22 p.m. when asked what time R3 was last repositioned, NA-B stated she did not know when R3 had last been repositioned. NA-B confirmed that staff did not write that down, and any information about repositioning would be by word of mouth.

On 6/11/20, at 3:47 p.m. R3 was observed in bed. When asked if R3 had been repositioned

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2 905	Continued From page 12	2 905		

recently, she responded, "not yet." R3's legs were still tilted on the right side, but it looked as though she had rolled onto her back a little bit, as her head was more flat on the pillow.

On 6/11/20 at 3:58 p.m. LPN-B stated if residents refused repositioning, she would go back in to re-approach and try again in 15 or 30 minutes. LPN-B stated checking in with the resident to encourage repositioning was another ball that staff had to try to keep in the air. LPN-B understood that R3 had gone on hospice recently, and was dealing with a lot, and should have some control over what care she wanted.

On 6/11/20, at 4:05 p.m. NA-B exited R3's room, and stated R3 had agreed to be repositioned. NA-B described moving R3 from her right side, to laying on her back on a pillow per resident preference. This was over 4 hours since R3 had been assisted to reposition.

On 6/11/20, at 4:11 p.m. registered nurse (RN)-A stated the nurse managers were currently monitoring wounds during weekly wound rounds. RN-A stated when R3 first admitted to the facility, she had a stage II pressure ulcer on her buttocks. A few weeks ago R3 was still walking, and staff were still treating the stage II wound she admitted with. RN-A stated in the past two weeks, R3 had declined according to the unit staff. RN-A stated R3 had been much more incontinent lately, and was not walking like she used to. RN-A was working on a MDS assessment due to the significant change. RN-A explained that the original stage II ulcer on the bottom had closed up earlier that week, but said now today during wound care before lunch, RN-A had seen a new open are that was 1 centimeter (cm) by 1 cm. RN-A described the entire sacral area as purple

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2 905	Continued From page 13	2 905		

in color, and said the new open area could be due to shearing or could be due to pressure. RN-A was working on updating the care plan due to the changes, and educated R3 about the importance of repositioning, and telling the staff if R3 thought she was wet. RN-A stated the expectation was for staff to offer repositioning at least every two hours. If R3 refused repositioning, RN-A expected staff to check in within maybe 15 or 30 minutes. RN-A expressed not wanting R3 to feel staff were disrespecting her choices, but wanted staff to re-approach before another two hours had passed. RN-A planned to update the care sheet to guide nursing assistants with when to re-approach if R3 refused repositioning.

The Resident Census document in the electronic medical record showed R3 was admitted to the transitional care unit on 4/10/20, and moved to her current long term care (LTC) unit on 5/26/20.

A Skin Integrity Event originally dated 4/10/20, noted R3 admitted with a stage II pressure ulcer on the right buttock, and that this area closed on 6/8/20. Skin Integrity Event dated 5/27/20, noted R3 had acquired a stage II pressure ulcer just above the coccyx. Skin Integrity Event dated 6/8/20 noted a stage II pressure ulcer to the right ear that was 0.2 cm by 0.1 cm.

A progress note dated 5/27/20, described the open area as 0.3 cm by 0.4 cm with 0.1 cm depth at the time it was discovered. In a progress note dated 5/28/20, the resident reported a history of skin breakdown in this area, with staff noting that R3 had spent almost all her time in bed since moving to her current unit. A progress note from 6/11/20 noted the pressure ulcer from admit on the buttock had resolved, but the new area on the sacrum now measured 1 cm by 1 cm, with depth

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2 905	Continued From page 14 of less than 0.1 cm. Staff reported resident sometimes declined brief changes or repositioning, and R3 was noted to have significant functional decline and increased incontinence since transfer to the LTC unit. R3 was on hospice with additional decline anticipated. Care sheet and care plan was updated to ensure repositioning every two hours, and re-approaching within 30 minutes if R3 declined. Requested a policy or procedure regarding re-approaching after a resident declined care planned interventions. On 6/12/20, at 12:16 p.m. the director of nursing (DON) sent an email and wrote that they did not have a policy specific to timing of staff re-approach, but said the stance would be to include the resident in the conversation of what was an acceptable plan for them and work on the care plan together, rather than making that decision without resident input. DON mentioned that the care plan was updated to include staff re-approaching after 30 minutes of refusal. The DON clarified it was a fine line of continuously upsetting or bothering residents with re-approach, versus abiding by their wishes and letting them be. The goal was for R3 to be comfortable, and staff planned to check in with R3 in the next week to see how things were going with the plan to re-approach after 30 minutes of refusal. The Prevention and Treatment of Skin Breakdown policy, copyright 2018, defined a stage II pressure injury as partial thickness skin loss with exposed dermis. These injuries commonly result from adverse microclimate and shear on the skin over the pelvis. The policy noted staff should evaluate current pressure reduction interventions and revise resident	2 905		

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2 905	Continued From page 15 centered care plan, re-evaluating as appropriate, and educate the resident on the pressure injury and care plan interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise policies and procedures related to repositioning of residents and educate staff. The DON or designee, could conduct audits to ensure compliance and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 905		