Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2024

Administrator
The Villas At The Park
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083
Cycle Start Date: October 24, 2024

Dear Administrator:

On October 24, 2024, a survey was completed at your facility by the Minnesota Department(s) 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 21, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 21, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 21, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs

offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 21, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Villas At The Park will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 21, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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.

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro B District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975

Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 24, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file

electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

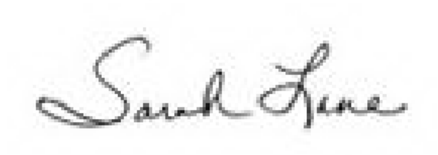
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT THE PARK	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

(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
E 000	Initial Comments On 10/21/24 through 10/24/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/21/24 through 10/24/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H50839481C (MN00107278). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/07/2024

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

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F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a self administration assessment (SAM) and a physician's order was completed to allow a resident to safely administer their own medication for 1 of 1 resident (R18) observed with medication at the bedside. Findings include: R18's quarterly Minimum Data Set (MDS) dated 9/5/24, indicated R18 had intact cognition, and cardiorespiratory conditions, pneumonia, respiratory failure, asthma, chronic obstructive pulmonary disease, or chronic lung disease. R18's Medical Diagnosis form undated, indicated R18 had chronic respiratory failure with hypoxia (low oxygen levels in the body), pneumonia due to other gram-negative bacteria, obstructive sleep apnea, dyspnea (shortness of breath), other specified chronic obstructive pulmonary disease, emphysema, and bronchiectasis (a condition where the airways widen and causes coughing with mucus and frequent infections) uncomplicated. R18's Physician Orders form indicated the following orders: 4/16/24, Advair diskus inhalation aerosol powder breath activated 500-50 microgram (MCG)/ACT	F 554	1. R18 was assessed for self-administration of medications and was found to be safe to self-administer his Advair. An order was obtained for self-administration of R18s Advair and that it can be stored at bedside. 2. This has the potential to affect residents at the facility with an inhaler order. All residents who wish to self-administer their inhaler received a SAMS assessment. Orders and care plan updated as needed. 3. Education was initiated with all nursing staff on self-administration of medications. Only residents with an order to self-administer are allowed to self-administer. The orders should be followed exactly as written by the provider. Policy for self-administration of medications was reviewed and remains current. 4. Director of Nursing and/or designee will complete 5 audits weekly of random resident rooms for 4 weeks to ensure that order for medication administration has been followed. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to	11/20/24

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F 554	Continued From page 2 (actuation) give 1 puff orally twice a day for asthma, administered by clinician. 4/18/24, Ipratropium-Albuterol inhalation solution 0.5-2.5 milligrams (MG) per 3 milliliters (ML) (nebulizer) inhale orally four times a day related to chronic respiratory failure with hypoxia. 8/28/24, ok for resident to self administer nebulizer after nursing set up medication. R18's Self Administration of Medication Evaluation form dated 8/28/24, indicated R18 was capable of self administration of inhalation medication to include nebulizer administration of medication. A box below indicated R18 was able to self administer nebulizer after set up by the nurse. Instruction for self administration of medications with the resident was completed by the nurse. R18 was able to demonstrate to the satisfaction of the nurse manager or designee the following: knowledge of what the medication was for, ability to recognize the medication and verbalize understanding of the purpose of the medication, the manual dexterity sufficient to self administer the medication accurately. Five check boxes were left unmarked which included: knowledge of the correct times to take medication, the ability to produce all currently used medication containers and that these reflect the current physician prescribed medications, that all medications are stored properly (if stored in resident's room), the ability to read the label/instructions on the medication container/package, and the ability to accurately report the medication use to nursing staff. The form lacked information R18 was capable of self-administering Advair powder which was not a nebulizer. R18's care plan dated 8/28/24, indicated R18	F 554	continue. 5. 11/20/2024	

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F 554	Continued From page 3 chose to self-administer nebulizer treatments after the nurse set the medication up. Interventions indicated to monitor usage of nebulizer treatments after resident completed nebulizer and nursing to administer all other medications and monitor response and side effects as needed. During interview and observation on 10/21/24 at 5:54 p.m., R18 had an Advair diskus on the bedside table. R18 stated they changed it so it could be left in the room so he could keep an eye on it. During observation on 10/22/24 at 3:01 p.m., R18 had the Advair diskus on the bedside table. During observation on 10/23/24 at 7:28 a.m., R18 was in bed and the Advair diskus was located at the bedside. During observation on 10/24/24 at 7:20 a.m., trained medication aide (TMA)-A entered R18's room to check his vital signs and moved the bedside table the Advair was located on. At 7:22 a.m., TMA-A stated they looked at the care plan to know what kind of cares a resident required. If a resident refused cares, it was reported to the supervisor and documented in the progress notes. TMA-A further stated in order for a resident to self administer a medication, they had to have a physician's order and stated R18 could not self administer medications. TMA-A stated they set up the nebulizer and timed it and went back. TMA-A stated he would have to look up whether R18 could self administer the Advair. At 7:26 a.m., TMA-A went into R18's room and verified Advair was located on the bedside table and asked R18 if someone left the medication	F 554		

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F 554	Continued From page 4 there the night before and R18 stated, "it's always there." At 7:27 a.m., TMA-A looked at the electronic medical record and viewed the medication administration record (MAR) and stated he did not see an order for R18 to self administer the Advair and called licensed practical nurse (LPN)-B over at 7:29 a.m. LPN-B viewed the orders form, opened the Advair order, and stated they did not have an order for R18 to self administer the Advair. LPN-B further stated they evaluated the patient and if the patient could administer a medication by themselves, they obtained an order from the provider. LPN-B opened the Self Administration of Medication Evaluation form dated 8/28/24, and verified the evaluation form did not mention the Advair inhaler and stated the items a resident could self-administer were checked in the check boxes, and if a resident was not able to do something the item was not checked. LPN-B further stated, according to the evaluation, R18 could not self administer the Advair. During interview on 10/24/24 at 7:39 a.m., LPN-A stated they completed a SAM assessment and obtained an order from the provider and the order would only include whichever medications were approved to self administer. LPN-A stated if there were unchecked items in the Self Administration of Medication Evaluation form, it indicated the resident could not do that portion of the assessment. During interview on 10/24/24 at 7:47 a.m., the director of nursing (DON) stated unless there was a physician's order and a completed SAM, a resident could not self administer a medication. The DON further stated the physician wrote the order for the nebulizer treatment and verified the	F 554		

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F 554	Continued From page 5 SAM evaluation form did not indicate Advair and only the nebulizer. A policy on self administration of medications was requested. A policy, Self-Administration of Medications, dated 2/2024, indicated residents have the right to self-administer medications if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. As part of the evaluation comprehensive assessment, the IDT assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. The IDT considers the following factors when determining whether SAM is safe and appropriate for the resident: the medication is appropriate for self-administration, the resident is able to read and understand medication labels, the resident can follow directions and tell time to know when to take the medication, the resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff, the resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow the medications and the resident is able to safely and securely store the medication. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.	F 554		

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F 604	Continued From page 6	F 604		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure freedom of movement was not restricted when multiple pillows were placed by nursing staff adjacent to	F 604	1. R104's fall intervention care plan was reviewed and remains current. All pillows under residents fitted sheet were removed, and room remains free of	11/20/24

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F 604	Continued From page 7 the resident's body, blocking the egress section of a perimeter mattress, underneath the fitted sheet which could not be removed easily by the resident for 1 of 1 resident (R104) reviewed for potential restraints. Findings include: R104's admission Minimum Data Set (MDS) dated 10/16/24, identified he had severely impaired cognition, and hallucinations and delusions had occurred. There was no behavior directed toward others and no rejection of care. Diagnoses included traumatic brain injury and anxiety. Falls occurred prior to entry but none since admission. Trunk restraints were not used. Extensive assist of two staff were required for bed mobility and transfers. R104's Care Area Assessment (CAA) for falls dated 10/22/24, was triggered due to a potential for falling due to poor muscle control and use of psychotropic meds. He was found on the floor several times since admission to TCU (transitional care unit), but it was determined that he crawled out of bed and put himself on the floor. R104's care plan dated 10/11/24, identified he was at risk for falls related to diffuse traumatic brain injury with loss of consciousness status unknown. Resident consistently made attempts and crawled out of low bed. Resident always had two fall mats on either side of bed and a perimeter mattress. A soft touch call light was in place and staff were also directed to follow any physical and occupational therapy instructions. Interventions lacked placing pillows under the sheet over the perimeter mattress egress section.	F 604	inappropriately placed pillows. 2. All residents with a mattress could be potentially affected. All resident rooms were audited and remain free of inappropriately placed pillows. Fall intervention care plans were also reviewed to ensure that none contained restrictive fall interventions. 3. Education was provided to all nursing staff to follow fall interventions listed in the resident's plan of care only, and to not use any methods that could restrict freedom of movement. Staff were educated on where to locate care plans. Staff educated and have access to fall policy. 4. The director of nursing and/or designee will complete 5 audits weekly of random residents to ensure that pillows are not placed inappropriately for restricting movement for 4 weeks. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 604	Continued From page 8 R104's admission care conference form dated 10/7/24, lacked discussion of pillows under the fitted sheet. R104's progress notes identified the following: 10/7/24 at 11:30 a.m., after discussion with family members, family members say resident often rolled out of bed during hospital stay. Resident family members express concern about this. Perimeter mattress provided to resident along with bilateral fall mats. Resident family member inquired about side rails as well. Will update provider and provide resident with adequate bed mobility devices. 10/8/24 at 1:15 p.m., resident exhibited inconsolable behaviors. Resident was unable to be redirected and exhibited visual hallucinations, agitation, and attempting to crawl out of bed on to floor repeatedly. DON (director of nursing) by bedside as 1:1 while provider and family were contacted. Resident was sent out to the hospital. 10/10/24 at 2:24 p.m., resident was readmitted back to the facility from the hospital and presented with an episode of exhibiting inconsolable behavior with visual hallucination and attempting to crawl out of bed multiple times. 10/11/24 11:03 a.m., IDT (interdisciplinary team) met to review resident behaviors. Behaviors include crawling from bed, calling out, outbursts of screaming, disrobing, visual/ auditory hallucinations. Per family/ POA, behaviors are like what resident exhibited in hospital post traumatic brain injury. Fall mats in place with low bed and perimeter mattress to help reduce resident desire to crawl out of bed and safety with	F 604		

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F 604	Continued From page 9 these behaviors. 10/13/24 10:17 a.m., resident was on the floor and ss (social services) assisted cnas (nursing assistants) to get him to bed. Resident was agitated and ss spent time with resident to keep him company and distracted. 10/14/24 at 8:24 p.m., throughout the first half of shift resident continuously tried to propel himself out of bed. Resident had one leg dangling outside the bed while screaming numerous times. Medications were administered and staff were provided for 1:1 supervision. 10/15/24 at 1:02 p.m., resident continues to exhibit baseline impulsive behaviors. 1:1 not needed at this time due to safety precautions in place and baseline behavior for resident post TBI. Therapy continues to work with resident, PT recommending Hoyer lift (full body lift) currently. 10/16/24 at 1:15 p.m., a care conference was held with the resident's power of attorney and IDT team and noted to refer to form for detail. The associated care conference form dated 10/24/24, lacked mention of using pillows over the perimeter mattress egress section. During observations and interviews on 10/21/24 at 5:28 p.m., R104 was in a low bed, the bed had bilateral grab bars and the left side of the bed was placed against the wall. On the right side of the bed facing out to the room, there were two large, cushioned mats on the floor. R104 attempted to crawl out of bed but could not get his legs up over pillows which were placed next to him, under the fitted sheet of the bed and over	F 604		

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F 604	Continued From page 10 the perimeter mattress egress section in the middle of the mattress. Nursing assistant (NA)-E and NA-F entered R104's room, R104 was trying to get his knees on the ground, his upper body was still on the bed behind the pillows, and he was grabbing out at the air with his hands. NA-E stated R104 was a fall risk and that's why the mats were on the floor and pillows under the sheet to keep him from crawling out of bed. NA-F stated R104 could not walk, needed to be transferred with a Hoyer lift and could not get out of bed per therapy recommendations. NA-E and NA-F positioned R104 him back into a central position in bed and adjusted three pillows back into place under the fitted sheet; two standard bed pillows and one decorative plush pillow. NA-E said R104 could not remove pillows under sheet next to him. During another observation at 10/21/24 at 5:39 p.m., NA-C entered the room with NA-E and NA-F and changed R104's incontinence brief and wet bed linen. No skin breakdown was observed. Then, NA-C placed the same pillows in the same position. NA-C stated the pillows were placed to keep him from falling out of bed, along with the floor mats and low bed. NA-C stated R104 required 1:1 staff over the weekend due to behaviors. When asked if the pillows as a fall intervention was listed on the care plan, NA-C, NA-E and NA-F stated they did not know. During an interview on 10/21/24 at 5:52 p.m., R104's guardian (FM)-A stated she had removed extra pillows from his bed before helping him to eat. Otherwise, the only other fall interventions she was aware of was floor mat, side rails (grab bars), perimeter mattress and a room change to be closer to the nurse's station. FM-A could not	F 604		

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F 604	Continued From page 11 recall if pillows were placed under the fitted sheet. FM-a stated he could crawl out of bed but couldn't likely stand due to his brain injury. During an interview and observation on 10/22/24 at 9:49 a.m., NA-B and NA-A stated they completed his morning cares already. R104 had floor mats next to the bed and pillows were again observed next to R104, under the fitted sheet blocking the mattress egress section. R104 made no attempts to get out of bed. During an interview and observation on 10/22/24 at 1:46 p.m., registered nurse (RN)-A stated fall interventions were listed on the care plan and on the Kardex for nursing assistants. RN-A went into R104's room and opened the closet to find the Kardex form, which was not in the plastic laminated paper holder. When asked about the pillows placed under R104's fitted bed sheet, he stated he believed those were in place to prevent rolling out of bed. R104's care plan was reviewed with RN-A, and the pillow intervention was not found. When asked if the pillows would create additional hazards during R104's attempts to crawl out of bed, he agreed it might increase the risk of injury or behaviors if he could not move around in bed. RN-A stated he did not think R104 had the cognitive capabilities to know how to remove the pillows from under the fitted sheet. During an interview on 10/22/24 at 1:55 p.m., RN-B stated she would not typically use pillows to block a perimeter mattress egress to keep a resident in bed, but pillows could be used on top of the sheet to prevent pressure sores, such as under the heels. RN-B stated the pillows would keep R104 from crawling out of bed, because he liked to turn onto his stomach in bed and put his	F 604		

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F 604	Continued From page 12 knees on the ground. During an interview and observation on 10/22/24 at 2:16 p.m., the director of nursing (DON) stated R104 required assistance to turn and reposition safety but could make movements on his own to roll the lower half of his body off the bed. The DON stated due to frequently crawling out of bed, R104's fall interventions included low bed, perimeter mattress, mats on the floor, soft call light, grab bars, and psychology review or medications. The DON stated pillows under the mattress were not included as a fall intervention and doubted it would qualify as a restraint, but agreed restricted movement could potentially contribute to skin integrity issues or mood or behavior issues. The DON and administrator accompanied surveyor to R104's room but were unable to view the pillows as they had been removed. The DON and administrator accompanied surveyor to talk to RN-B to see who removed the pillows. RN-B stated he removed the pillows in case they were considered a restraint. The administrator and DON asked RN-B if family requested staff to place pillows under the sheet and RN-B said "no". The administrator stated if restraints were used there needed to be a thorough assessment first of the system used, with IDT and physician involvement, and in this case, there was not, and staff education should be completed. During an interview on 10/22/24 at 2:31 p.m., the physical therapist (PT) stated she had evaluated R104 upon admission and he would have a hard time removing pillows under a fitted sheet. The PT stated she would not want pillows blocking the egress on the perimeter mattress as it was not a realistic intervention. Mobility should be allowed	F 604		

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F 604	Continued From page 13 with the least number of obstacles in the way. During follow up observation on 10/23/24 at 7:16 a.m., NA-B was seated in R104's room. NA-B stated R104 started on 1:1 supervision today so her job was to sit here and redirect him. During an interview on 10/23/24 at 8:07 a.m., licensed practical nurse (LPN)-A stated she was unsure how R104's night went but they got him a ceiling projector for entertainment and to keep his focus. A policy on restraints was requested and not provided. The facility's policy titled Fall Prevention and Management dated 2/2024, identified facility staff would identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. If falling recurred despite initial interventions, staff would implement additional or different interventions, or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on the nature of or type of fall, until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. The policy lacked guidance on how to ensure different interventions were not restraints.	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		11/20/24

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F 684	Continued From page 14 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure orders for compression were implemented for 2 of 2 residents (R40, R45) reviewed for edema. Findings include: R40's Optional State Assessment (OSA) dated 9/8/24, indicated R40 had intact cognition, did not reject cares, and required limited assistance with bed mobility, transfers, and toilet use. R40's admission Minimum Data Set (MDS) dated 9/8/24, indicated they had no impairment to range of motion, used a walker, and required partial to moderate assistance for showering/bathing, dressing lower body, and donning and doffing footwear. R40's Medical Diagnosis form undated indicated the following diagnoses: heart failure, difficulty in walking, cognitive communication deficit, neoplasm (tumor) of unspecified behavior of brain, malignant neoplasm of unspecified part of right bronchus or lung, secondary malignant neoplasm of brain, and metabolic encephalopathy.	F 684	1. R40 and R45's orders were reviewed and remain current. Compressions socks are now in place for both R40 and R45. 2. All residents with an order for compression socks have the potential to be affected. All resident orders with compression socks were reviewed, and implementation of socks validated by nurse leadership. 3. Nurses were all educated to follow orders for compression socks, and to document in a progress note any care refusals that may occur. 4. The director of nursing and/or designee will complete 2 audits weekly of random residents to ensure that orders were followed, and compression socks are implemented for resident care for 4 weeks. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 684	Continued From page 15 R40's Physician Orders form indicated the following orders; 10/11/24, torsemide 40 milligrams (MG) give 40 mg by mouth twice daily for heart failure and lower extremity edema. 10/18/24, Knee high compression stockings on every day and evening shiftt. R40's care plan dated 9/3/24, indicated R40 had an alteration in cognition due to a neoplasm of the brain and metabolic encephalopathy (brain dysfunction). R40's care plan dated 9/3/24, indicated R40 had a self care deficit due to a neoplasm of the brain and metabolic encephalopathy and required partial moderate assistance with lower body dressing. The care plan lacked information R40 required compression stockings, or had edema. R40's nursing assistant care guide indicated R40 was independent with dressing, required assistance of one staff with activities of daily living (ADLs), and lacked information R40 had compression stockings, or had edema. R40's progress notes were reviewed and lacked documentation R40 refused compression stockings. During interview and observation on 10/21/24 at 1:58 p.m., R40 was in bed, legs were swollen, and feet were up in the bed. R40 stated she had compression stockings she wore at bedtime. R40 was not wearing any compression stockings.	F 684		

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F 684	Continued From page 16 During observation on 10/21/24 at 2:17 p.m., R40's compression stockings were not visible in R40's room. During observation on 10/22/24 at 9:56 a.m., R40 had white compression socks on the left hand rail on the side of the bed towards the window. During observation on 10/22/24 at 10:11 a.m., R40 was in bed and her compression stockings were located on the hand rail. During interview on 10/23/24 at 10:40 a.m., R40 did not have compression stockings on, stated she just started using them, and then stated she could not tell if she was using them at this time. R40 had compression stockings located on the bed rail closest to the window. R40 stated the compression stockings did not hurt her legs. During interview on 10/23/24 at 11:01 a.m., nursing assistant (NA)-A stated R40 got up to use the bathroom independently and further stated R40 could get dressed by herself. NA-A thought R40's family member put clothing out for R40 and thought either the nurse or therapy put on R40's compression stockings. During interview on 10/23/24 at 11:16 a.m., registered nurse (RN)-A stated in general nursing assistants are educated on how to put on compression stockings and stated the NAs knew what kind of cares a resident required based on the care plan and a Kardex. RN-A further stated R40 had swollen legs two weeks earlier, was monitored closely, torsemide was increased due to retention of fluid, and compression stockings were ordered to reduce swelling. RN-A stated R40 was not able to put on or take off the	F 684		

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F 684	Continued From page 17 compression stockings by herself and added R40 was confused. Further, RN-A stated they provided education to the aides and stated the NAs should be applying R40's compression stockings and stated the Kardex was usually in the closet, but stated it was not located in R40's closet. R40 was in bed and dressed and stated the compression stockings could be applied. R40 asked repeatedly whether she wore the stockings in the morning and at night. At 11:25 a.m., RN-A donned both compression stockings and stated it was the NA's responsibility to donn the compression stockings and would have been beneficial to have the Kardex in the room. During interview on 10/23/24 at 11:39 a.m., the director of nursing (DON) stated aides documented in point of care where the tasks are and used care guides to know what cares a resident required. The DON stated they did not use Kardex and revamped the careguides and the nurses had access to the care plans. The DON verified R40 had an order for compression stockings. R45's quarterly Minimum Data Set (MDS) dated 10/4/24, indicated R45 was cognitively intact and had diagnoses of chronic venous insufficiency (improper functioning of the vein valves in the leg, causing swelling and skin changes) and leg pain. Had no rejection of care and required maximum assistance with lower extremity cares. R45's provider orders dated 9/18/24, indicated R45 required compression socks on in the morning and off in the evening. R45's Medical Administration Record (MAR) and	F 684		

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F 684	Continued From page 18 Treatment Administration Record (TAR) dated 10/2024, lacked documentation R45 used or refused compression socks. R45's progress note dated 10/22/24 at 3:16 p.m., stated R45 had edema and utilized compression socks. The note also indicated R45 wore compression socks before admission. R45's care plan reviewed 10/22/24, lacked identification of R45's edema and intervention of compressions socks. During observation on 10/22/24 at 8:23 a.m., registered nurse (RN)-B was in R45's room helping them get dressed and could only find one compression stocking, so they were not applied. RN-B stated that they would see if they could find another. RN-B assisted R45 to stand, pulled up their pants, and helped them walk to a chair with bare feet. During observation on 10/23/24 at 7:27 a.m., R45 was wheeling in their wheelchair into the elevator and was not wearing compression socks. During observation and interview on 10/22/24 at 8:23 a.m., R45 stated staff did not put his compression socks on him because they could not find them, and the socks needed to be ordered. R45 stated they were required to reduce the swelling in his lower legs. R45's lower legs had hard, pitting edema on the ankles and skin folds. When interviewed on 10/23/24 7:59 a.m., R45 stated the facility did not have their socks, as the workers misplaced one of them. R45 stated their legs felt better when wearing them, and they had	F 684		

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F 684	Continued From page 19 been missing for about a week. R45 stated one sock was on the commode rail, however, was not visible. R45 was unsure if the compression socks were ordered. When interviewed on 10/23/24 at 9:11 a.m., nursing assistant (NA)-J stated they helped R45 with their cares such as pulling up pants. NA-J stated they did not usually work on this side of facility, and did not have a current care plan sheet. NA-J stated they did what resident requested, and did not see or know if compression socks were ordered for R45. When interviewed 10/23/24 at 10:41 a.m., RN-B stated the cares that are expected to be done for edema would be to follow doctor's orders, including compression socks, diuretics and weight checks, and to update the provider if there are changes. RN-B did not know if R45 had orders for compression socks, and confirmed they were not listed on the care plan or electronic medical record. When interviewed 10/23/24 1:43 p.m., licensed practical nurse (LPN)-A stated if a resident had edema, staff would gather information and call the doctor to get orders for medication and compression socks, and these would be listed in the electronic record and the care guide sheets. They expected staff to document cares and medications given on the MAR/TAR. They confirmed R45 should wear compression socks due to a diagnosis of chronic venous insufficiency. When interviewed on 10/23/24 at 2:00 p.m., the director of nursing (DON) stated the expectation of staff was to follow orders for wearing	F 684		

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F 684	Continued From page 20 compression socks and document them in a progress note. They stated it was important to follow doctor's orders to treat the diagnosis and be compliant. A policy regarding edema management and following orders was requested but not provided. A policy, Activities of Daily Living dated 3/31/23, indicated the facility will provide the necessary care and services to ensure that a resident's abilities in ADLs do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. The facility will ensure a resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the ADLs.	F 684		
F 686 SS=G	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 review, the facility failed to comprehensively	F 686	1. R30 and R33 have had interventions put in place to prevent further skin	11/20/24

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F 686	Continued From page 21 assess and implement pressure ulcer interventions for 2 of 2 residents (R30, R33) identified at risk for pressure ulcers. This resulted in actual harm when R30 developed two deep tissue injuries which worsened to unstageable pressure injuries on the heels after admission, and R33 developed a stage two pressure ulcer after admission that worsened to an unstageable pressure ulcer. Additionally, the facility failed to reposition 1 of 2 residents (R30) in accordance with the current care plan, and failed to accurately stage a pressure ulcer and failed to accurately assess nutritional needs and implement provider ordered nutritional interventions to aide in healing for 1 of 2 residents (R33) reviewed for facility acquired pressure ulcers. Findings include: The National Pressure Injury Advisory Panel (NPIAP) guidance dated 2016, identified a deep tissue pressure injury (DTPI or DTI) as persistent non-blanchable deep red, maroon, or purple discoloration with intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration, or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature changes often preceded skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle, or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, stage 3 or stage 4).	F 686	breakdown, including updating repositioning and offloading schedules. R30 and R33 had a new Braden assessment completed and interventions reviewed. R30 and R33 were both assessed by the facility dietician for any additional supplements and/or dietary interventions needed to aid in wound healing. R33 was given double portions at meals. Wound rounds completed by in-house wound team and facility rounding wound care provider. The staging of wounds was reviewed with certified wound nurse practitioner for accuracy and updated as appropriate. Care plans have been updated to reflect any changes. 2. All residents have the potential to be affected. A Braden was completed on all in house residents to assess risk for skin breakdown. Any residents scoring below an 18 on their Braden received a skin integrity care plan review and dietician was notified to complete nutrition review. All residents with current pressure wounds have been reviewed for appropriate and accurate staging, dietary and therapy interventions. Orders and documentation have been updated if needed. 3. Education provided to nurses regarding evaluation for risk of skin breakdown, and education to all nursing staff on implementation of preventative measures to prevent the development of pressure ulcers. Pressure ulcer staging and education reviewed with facility rounding wound care practitioner. Dietician	

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F 686	Continued From page 22 An unstageable pressure injury was defined as obscured full-thickness skin and tissue loss, full-thickness skin, and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it was obscured by slough or eschar (dead tissue). If slough or eschar was removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Additionally, the NPIAP Evolution of Deep Tissue Pressure Injury process dated 1/8/21, identified DTI was one of the most serious forms of pressure injury. The process leading to DTI included: 1. 48 hours after a pressure event a DTI presents as intact, discolored skin from pressure 2. 24 to 48 hours after intact skin color change, the discolored skin blisters 3. Seven to 10 days after intact skin color change the DTI is classified as an unstageable pressure injury related to necrosis (death of body tissue). R30's admission Minimum Data Set (MDS) dated 7/2/24, identified she had intact cognition, no behaviors, and no rejection of care. Substantial/maximal assistance was required for lower body dressing and putting on/taking off footwear. Walking was not attempted due to medical condition or safety concerns. Diagnoses included adult failure to thrive, cauda equina syndrome (spinal disc compression with symptoms that may include less or changed sensation between the legs, the back of the legs, the feet, or the heels), lumbosacral radiculopathy	F 686	educated on accurate nutrition assessment and timeliness of dietary interventions. 4. The director of nursing and/or designee will audit 5 residents weekly to validate skin interventions are in place, validate no change in weight/nutrition, weekly skin form completed, and observe turn/repo or offloading if indicated to prevent the development of pressure ulcers x 4 weeks. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 686	Continued From page 23 (compressed nerve roots in lower back which include symptoms of numbness, tingling or reduced sensation in the legs), and presence of left artificial knee joint. R30 was at risk for pressure ulcers but had none. Pressure reducing device for chair and bed were selected as current treatments. Turning and repositioning program was not selected. R30's admission pressure ulcer Care Area Assessment (CAA) dated 7/2/24, was triggered due to risk of potential alteration in skin integrity related to frequent incontinence of bowel. Staff assistance was required for bed mobility and transfers, and the Braden skin risk assessment identified her to be at risk for pressure ulcers. Risk was further complicated by presence of indwelling urinary catheter, several significant comorbidities, recent complicated hospitalizations, and history of noncompliance and refusal of cares. R30 had no pressure injuries and worked with physical and occupational therapy. R30's hospital progress note (prior to facility admission) dated 6/19/24, identified she was unable to move her legs and had diminished sensation. R30's admission 48-hour care plan dated 6/27/24, identified she required assist with bathing, dressing, hygiene, transfers, and movement in bed. A pressure redistribution mattress was present on the bed and chair, and skin integrity would be monitored daily during cares and weekly by nurses. Turn and reposition or reminders were not selected as an intervention.	F 686		

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F 686	Continued From page 24 R30's comprehensive care plan dated 6/27/24, identified she had an alteration in skin integrity due to adult failure to thrive and surgical incision. The care plan lacked risk factors affecting sensation in the lower legs such as cauda equina syndrome and lumbosacral radiculopathy. Interventions lacked floating heels, heel protection, or to turn and reposition every two to three hours and as needed. R30's comprehensive care plan updated 8/8/24, identified she had an alteration in skin integrity related to adult failure to thrive, history of coccyx ulcer pressure injury, surgical incision, and DTI on bilateral heels. New interventions also dated 8/8/24, included heel lift boots at all times when in bed; and on 8/24/24, an intervention was added to turn and reposition or give reminders to offload every two to three hours and as needed. R30's quarterly MDS dated 9/24/24, identified additional diagnoses of anxiety, neurogenic bladder, osteoarthritis of the knee, muscle weakness, and difficulty walking. R30 was at risk for pressure ulcers and now had two unstageable pressure ulcers with suspected DTI in evolution. Nutrition interventions were in place to manage skin problems, and pressure ulcer care treatment was provided. R30's admission Braden Scale for Predicting Pressure Sore Risk dated 6/26/24, had not identified any sensory perception problems in the lower legs, which would have increased the risk scoring. R30's nurse practitioner (NP) admission note from the in-house provider group dated 6/28/24 at 12:00 a.m., identified she was severely	F 686		

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F 686	Continued From page 25 deconditioned from long hospitalization as well as recent total knee arthroplasty (replacement) on 5/2024. R30's admission Skin Evaluation and Skin Risk Factors assessment dated 6/27/24, identified an overall Braden score of 15-18, which was mild risk. A surgical incision was present on the lower back. A pressure reducing ultra foam mattress was in place, however turning and repositioning schedule or floating the heels were not identified as an intervention. R30's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 6/27/24 through 7/25/24, identified therapy attempted to transfer R30 to wheelchair with EZ stand (standing lift). R30 complained of too much pain even before hips were lifted off the bed. Further transfers were declined. Additionally, R30 required maximum assist of staff to sit on edge with both hands supporting her body on the sides of her hips. Once her hands were lifted, she was unable to maintain sitting balance for more than a few seconds. R30's OT Discharge Summary dated 6/27/24 through 8/15/24, identified she had achieved the highest practical level. She required maximum assistance with Hoyer for transfer (full body mechanical lift) and maximum assistance for lower body dressing. R30's mobility function score was zero (score range zero to 12; with 12 being the highest function). R30's Physical Therapy (PT) Evaluation and Plan of Treatment dated 6/28/24 through 7/27/24, identified a medical history of osteoarthritis (OA) and surgical procedure (s/p) bilateral total knee	F 686		

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F 686	Continued From page 26 arthroplasty (TKA), right knee being done on 5/1/24, and recent prolonged hospitalization for osteomyelitis and discitis. R30 could not care for herself at home and required placement in the transitional care unit (TCU). Right and left lower extremity strength was impaired. R30's PT Discharge Summary dated 6/28/24 through 8/15/24, identified she had exhausted benefits and declined treatment. A Hoyer lift was still recommended due to lower extremity weakness and low tone. R30 was unable to stand due to poor leg strength and poor tone. R30's mobility function score was three (score range zero to 12; with 12 being the highest function). R30's Weekly Skin Assessments dated 6/26/24 through 8/8/24 had not noted the heels were offloaded. R30's progress note dated 8/8/24 at 2:10 p.m., identified discoloration (DTI) noted on bilateral heels during wound rounds. The progress note identified R30 consistently offloaded heels with pillows in bed, however, this was not listed as an intervention in the care plan or nursing assistant tasks or documented prior to the DTI. R30's weekly NP-A Wound Consult forms identified the following: -8/1/24, seen for post-surgical spinal wound routine wound evaluation. R30 had multiple comorbidities affecting wound healing and wound progression, as well as risk for wounds including risk for malnutrition, limited mobility, muscle weakness which predisposed patient to wounds due to weakness, and inability to move about or reposition. Reposition per facility protocol/policy,	F 686		

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F 686	Continued From page 27	F 686		

encourage good nutrition and movement habits, continue to follow-up per routine schedule or sooner if needed. Heel ulcers were not noted on this consultation.

- 8/8/2024, seen for surgical incision, impaired skin integrity, limited mobility, and muscle weakness. R30 was resting in bed on her back and accepting to wound cares. DTIs were noted on bilateral heels, and it was again noted R30 had limited mobility especially in her lower extremities. Skin prep (topical barrier) was applied, and heels were offloaded with pillows to free float heels. Nursing was instructed to provide Prevalon boot (heel protection boot) for offloading when available. Wound care orders included: Skin prep/open to air-daily, float heels, Prevalon boot on daily when available, follow wound care team weekly. The wounds were identified as "new, in-house acquired" with the right heel DTI measuring 4.62 centimeters (cm) long and 4.92 cm wide. The left heel DTI measured 3.21 cm long by 3.13 cm wide.

-8/15/24, resting in bed on her back and accepting to wound cares. The DTI to bilateral heels increased in size and she had limited mobility especially lower extremities. Skin prep applied and offloaded with bunny boots (foam cushioned boot). Prevalon boots were on order. Continue to encourage aggressive offloading. Wound care orders otherwise remained the same. The right heel DTI measured 4.21 cm long and 3.61 cm wide. The left heel DTI increased in size and measured 3.21 cm long by 3.73 cm wide.

- 8/23/24, resting in bed on her back and accepting to wound cares. Bilateral heel DTIs

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F 686	Continued From page 28 were stable and drying. No new open areas noted. Bunny boots were on for offloading. Aggressive offloading and repositioning were encouraged. Wound care orders otherwise remained the same. The right heel DTI measured 3.31 cm long and 3.08 cm wide. The left heel DTI measured 3.1 cm long by 3.75 cm wide. -8/29/24, Wound care orders otherwise remained the same. The right heel DTI increased in size and measured 3.84 cm long and 4.64 cm wide. The left heel DTI measured 2.97 cm long by 3.69 cm wide. -9/5/24, resting in bed on her back and accepting to wound cares. Bilateral heels are stable and eschar now. R30 continues to wear offloading boots. No new open areas noted. Encouraged aggressive offloading and repositioning. Wound care orders otherwise remained the same. The right heel DTI measured 3.89 cm long and 4.07 cm wide. The left heel DTI measured 3.4 cm long by 3.21 cm wide. -9/12/24, resting in bed on her back and accepting to wound cares. Bilateral heels were improving and getting smaller. Heels are now eschar and dry. Wound care orders otherwise identified: skin prep/open to air-daily, float heels, Prevalon boot on daily when available, heel protectors on both feet always when in bed. Must float heels with folded pillows in addition to heel boots every shift. The right heel DTI measured 3.64 cm long and 4.04 cm wide. The left heel DTI increased in size measured 2.53 cm long by 4.01 cm wide. - 9/19/24, bilateral heels were stable, however the wounds were peeling and draining at the edges.	F 686		

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F 686	Continued From page 29 R30 was compliant with wearing her Prevalon boots. Wound care orders otherwise remained the same. The DTI were now classified as "in-house acquired unstageable pressure ulcers due to slough and/or eschar covering the wound bed". The right heel unstagable pressure ulcer measured 2.84 cm long and 3.03 cm wide. The left heel unstagable pressure ulcer increased in size measured 3.69 cm long by 2.35 cm wide. - 9/26/24, identified bilateral heels were stable, however the wounds were peeling but appeared to be smaller. R30 was compliant with wearing her Prevalon boots. Wound care orders included: stable, clean with wound cleanser, apply Medihoney, cover with foam dressing one time a day AND as needed, float heels, Prevalon boots on daily when available, heel protectors on both feet always when in bed. Must float heels with folded pillows in addition to heel boots every shift. The right heel unstageable pressure ulcer measured 3.33 cm long and 1.94 cm wide. The left heel unstageable pressure ulcer measured 2.7 cm long and 2.79 cm wide. -10/2/24, bilateral heel unstageable pressure sores are improving. All wounds mechanically debrided (removal of dead tissue) and redressed. Wound care orders otherwise remained the same. The right heel unstageable pressure ulcer measured 2.15 cm long and 3.14 cm wide. The left heel unstageable pressure ulcer measured 1.96 cm long and 2.97 cm wide. -10/10/24, R30 was in bed resting on her back with pillow offloading her feet and accepting to wound cares. Noncompliant with Prevalon boots although strongly encouraged to wear to promote wound healing. The wound dressing removed	F 686		

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F 686	Continued From page 30 from the heels was not as ordered. Nurse manager was present when dressings were removed. The bilateral heel wounds were deteriorating. The wound beds were very sloughy (soft and watery) with drainage. All wounds mechanically debrided and redressed. Unable to sharps debride due to intolerance. Always discussed importance of aggressive offloading and repositioning and compliance with Prevalon boots. The right heel unstageable pressure ulcer increased in size measured 2.98 cm long and 3.45 cm wide. The left heel unstageable pressure ulcer measured 2.1 cm long and 1.43 cm wide. -10/17/24, R30's right heel wound deteriorated. Left heel was stable. The open wound beds were very sloughy with necrotic tissue and drainage. All wounds mechanically debrided and redressed. Unable to sharps debride due to intolerance. Wound culture was collected. Wound care orders remained the same. The right heel unstageable pressure ulcer increased in size measured 4.52 cm long and 4.79 cm wide. The left heel unstageable pressure ulcer measured 1.81 cm long and 2.23 cm wide. R30's corresponding progress note dated 10/17/24 at 1:41 p.m., identified wound care orders changed to Santyl ointment instead of Medihoney. During the start of a continuous observation on 10/23/24 at 7:05 a.m., R30 was in bed on her back, eyes closed. The head of the bed was elevated about 10 degrees. R20 had blue cushioned boots on both feet with wedge cushion underneath her calves, visible because blankets were pulled up over her feet.	F 686		

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F 686	Continued From page 31 -At 8:12 a.m., licensed practical nurse (LPN)-A entered R30's room with a breakfast tray. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 8:15 a.m., nursing assistant (NA)-D entered R30's room and said good morning, ok you want to sleep. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 10:00 a.m., LPN-A entered and removed her breakfast tray. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 10:02 a.m., LPN-A entered R30's room. R30 asked LPN-A to pull the blanket over her feet. R30 remained in the same position without moving in bed and was not offered to offload and reposition. -At 10:10 a.m., trained medical assistant (TMA)-A knocked and entered R20's room for a safety check and exited. R30 remained in the same position without moving in bed and was not offered to offload and reposition. It was three hours and five minutes since R30 has been repositioned. -At 10:26 a.m., TMA-A brought R30 her medications. R30 brought the medication cup to her mouth and then drank from a cup of water, without elevating her head of bed or offloading her body. R30 remained in the same position without moving in bed and was not offered to offload and reposition. When asked, TMA-A stated R30 was not able to fully offload her lower body and staff were expected to do that for her.	F 686		

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F 686	Continued From page 32	F 686		

During a follow up interview with R30, she stated staff were supposed to come in and move her upper and lower body and they had not. R30 was agreeable to get staff to help her reposition.

-During a follow up interview at 10:31 a.m., NA-D stated a resident was typically repositioned every two to three hours. When night shift left and day shift came on, last repositioning times were discussed. NA-D stated he did not recall if R30's repositioning was discussed.

-During an interview at 10:32 a.m., RN-A stated staff should review the care plan to determine how often to reposition. RN-A was not aware it had been almost three and a half hours since R30 was last repositioned, and he would get the NAs to help her because R30 could not move her lower body to fully offload. RN-A was not sure if orders to float her heels were present before the development of pressure ulcers. RN-A stated if a resident had reduced feeling in the legs, they would consider adding in the intervention to float heels to prevent pressure ulcers. RN-A stated he would get staff to reposition R30.

-At 10:35 a.m., NA-A and NA-D entered R30's room. NA-A stated R30's legs and knees do not bend. NA-A and NA-D stated R30 was currently compliant with floating her heels and wearing the boots in bed. NA-A stated R30 should have been repositioned by now, but they were busy and R30 had not called for assistance.

-At 10:55 a.m., the end of the continuous observation, NA-A and NA-D assisted R30 to turn to her side with maximal assist and provided personal cares. Wrinkles from the mattress and pillows were noted on her back and legs. There

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F 686	Continued From page 33 were indentations on lower legs from the wedges floating her heels. It was three hours and 50 minutes since R30 was last repositioned. During an interview on 10/23/24 at 12:10 p.m., the wound care consultant nurse practitioner (NP)-A stated R30 was at high risk for pressure ulcers upon admission, due to surgery, not able to move on her own, and malnutrition, and had to be pushed to adequately reposition. R30's level of assist required for offloading had not improved since her admission. NP-A stated the root cause of DTI was most likely laying in bed with the heels always on her bed. NP-A stated R30's heels were at high risk for breakdown when she was admitted, and floating the heels would be a standard intervention for someone with limited mobility. NP-A stated heel protection measures such as cushioned boots or floating the heels could have prevented the pressure ulcers. NP-A stated prior to the pressure ulcer development, she did not observe R30's heels floated during weekly wound rounds. NP-A stated repositioning every two to three hours, per care plan, should be appropriate if she's compliant, going almost 4 hours could contribute to further pressure ulcers due to R30 not being able to offload. NP-A stated the pressure wounds at this point were unstageable and were classified as facility acquired. During an interview on 10/24/24 at 11:11 a.m., the director of nursing (DON), stated risk factors for pressure ulcers included being in bed most of the time, malnutrition, and improper footwear. The DON stated the main intervention to prevent pressure ulcers on the heels were weekly nursing assessments, and interventions included turn and reposition, float the heels, and offload pressure.	F 686		

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F 686	Continued From page 34 The DON stated R30 was at risk upon admission and after the development of the pressure ulcers she was at moderate risk. The DON stated R30 was given a risk and benefits form for not complying with wound care, but this was after the pressure ulcers had developed. The DON stated heel protection was not included in R30's care plan upon admission due to determined risk. Additionally, R30 had pigmented skin color which made it more difficult to see pressure ulcer formation. When asked if pigmented skin color would have increased R30's risk for the admission skin assessment the DON stated she was unsure. When asked about a root cause analysis, the DON stated the pressure ulcers developed after admission and she could find a root cause analysis form to share, however, she did not have the form at this time. The DON stated development of a DTI was likely from being in bed most of the shift. The DON stated after R30's pressure ulcers, education was completed with the staff on assessing pigmented skin color and on pressure ulcer prevention measures. The DON stated refusals of repositioning would be listed in R30's "Tasks" section of the electronic medical record, however, this documentation was not provided. The undated Pressure Injury Root Cause Analysis (RCA), identified due to pigment of resident skin, staff did not perceive the discoloration on heels to be pressure related. The RCA lacked a cause such as medical devices mattress pressure, friction or shearing, wheelchair foot rest pressure, or type of footwear utilized. During an interview on 10/24/24 at 12:42 p.m., the PT who had worked with R30 stated the amount of movement R30 had in her lower legs	F 686		

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F 686	Continued From page 35 upon admission was the level of someone that was a paraplegic (paralyzed from the waist down). The PT stated R30's status remained the same because she still needed a full Hoyer lift to transfer. The PT stated R30 could not fully offload, especially in the lower body. The State Operations Manual (SOM) defined the various presure ulcers as follows: A stage one pressure injury is intact skin with a localized area of redness that is non-blanchable (does not turn white when pressed). A stage two pressure ulcer is partial thickness loss of the skin with exposed dermis, presenting as a shallow open ulcer. It may also present as an intact or open/ruptured blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) are not present. A stage three pressure ulcer is full thickness loss of the skin in which subcutaneous fat may be visible. Additionally, slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) or eschar may be visible but does not obscure the depth of the tissue loss. A stage four pressure ulcer is full thickness loss of the skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and or eschar may be visible on some parts of the wound bed. Undermining and or tunneling often occur. If slough or eschar obscures the wound	F 686		

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F 686	Continued From page 36 bed, it is an unstageable pressure ulcer. An unstageable pressure ulcer is obscured full thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. If slough or eschar is removed, a stage three or stage four pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then reclassified stage should be assigned. A deep tissue pressure injury (DTPI) is intact skin with localized area of persistent non blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue (deepest layer of skin), granulation tissue (new connective tissue), fascia (connective tissue), muscle or other underlying structures are visible, this indicates a full thickness pressure ulcer. Once a deep tissue injury opens to an ulcer, reclassify the ulcer into the appropriate stage. R33's Medical Diagnoses form indicated a right knee effusion, mild cognitive impairment, muscle weakness, difficulty in walking, deficiency of other specified B group vitamins, type 2 diabetes mellitus with diabetic polyneuropathy (a type of nerve damage that affects multiple nerves in the body), disease of the spinal cord, other tear of the lateral meniscus, current injury of the right knee,	F 686		

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F 686	Continued From page 37 and chronic pain. R33's quarterly MDS dated 7/10/24, identified intact cognition, did not reject care, had impairment in range of motion (ROM) to one side of upper and lower extremities, was independent in rolling from lying on the back to the left and right side, was 60 inches tall and weighed 229 pounds, and had no or unknown weight loss. R33's quarterly MDS dated 9/26/24, identified a cognitive assessment was not completed, did not reject care, was 72 inches tall and weighed 230 pounds, did not have 5% or more weight loss in the last month. Further, R33 was at risk for pressure ulcer development and had one or more stage one pressure ulcer. R33's Optional State Assessment (OSA) MDS dated 9/26/24, identified R33 required extensive assistance with bed mobility, transfers, and toileting. R33's CAA dated 5/30/24, identified R33 was at risk for pressure ulcers due to the need for extensive assistance with bed mobility and incontinence, and did not have a pressure ulcer but would be addressed in the care plan to avoid complications and minimize risks. R33's nutritional status care plan dated 5/27/24, identified R33 was on a regular diet with no concerns reported. R33 had the following interventions: diet per physician order, obtain weight monthly, registered dietician or culinary director to consult as needed, the resident is on a regular diet with no concerns. Further an intervention dated 7/10/24, was	F 686		

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F 686	Continued From page 38 written, "Dietary Preferences (Specify)". No dietary preferences were documented. R33's alteration in mobility care plan dated 5/27/24, identified R33 required an assist of two with transfers and partial to moderate assistance with rolling left to right in bed. R33's risk for alteration in skin integrity care plan dated 5/28/24, indicated R33 had a stage one pressure ulcer to the left heel and had the following interventions: 5/28/24, pressure redistribution cushion to wheelchair, and chair. 6/14/24, monitor skin integrity daily during cares. Weekly skin inspection by the nurse. 6/14/24, turn and reposition or reminders to offload every two to three hours and as needed as resident allows. 9/19/24, heel boots at all times while in bed. 10/21/24, low air loss air bed, pressure redistribution. The care plan lacked an intervention for a wedge cushion in the bed. R33's skin integrity care plan dated 9/24/24, indicated staff were to follow current risk/benefit form, and interventions included a risk benefit form was completed an on file for skin integrity noncompliance with skin interventions 9/24/24. R33's alteration in blood sugar care plan dated 10/2/24, indicated R33 had a potential for alteration in blood sugar due to diabetes, and interventions included providing a diet as ordered and encourage R33 to follow the prescribed diet. R33's group sheet indicated R33 had wounds and required assist of one for bed mobility.	F 686		

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F 686	Continued From page 39 R33's physician orders indicated the following orders: 5/27/24, regular diet, regular texture, regular thin consistency. 8/8/24, weekly skin inspection by licensed nurse. 9/19/24, 1. left heel wound, skin prep to heel and allow to dry. 2. boots and float heels freely. 10/21/24, air mattress monitor working order and replace as needed. The physician orders were reviewed and lacked any orders for any nutritional supplement. R33's Braden Scale for Predicting Pressure Sore Risk forms were reviewed and identified the following: 7/9/24, R33 scored a 16 indicating R33 was at risk for developing a pressure sore. 9/19/24, R33 scored a 16 on the Braden scale. 9/26/24, R33 scored a 14 indicating R33 was at moderate risk for developing pressure ulcers. R33's weights were reviewed and indicated the following: 5/25/24, 232.8 pounds 5/26/24, 230 pounds 6/2/24, 231.5 pounds 6/16/24, 230.7 pounds 6/30/24, 230 pounds 7/7/24, 229 pounds 8/4/24, 230 pounds 9/24/24, 219 pounds 10/11/24, 217 pounds R33's Clinical Nutrition Evaluation form dated 5/30/24, indicated R33's height was documented as 60 inches and weighed 230 pounds and BMI (body mass index) was not documented.	F 686		

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F 686	Continued From page 40 R33's Clinical Nutrition Evaluation form dated 7/10/24, Under the heading, "Dietary Preferences Likes/Dislikes" indicated large portions, likes cereal, bacon, eggs, and toast, juice, milk. Further, under the heading, "Skin Condition" indicated R33 had no skin issues noted. Under the heading, "Additional Information" indicated R33's current weight was 230 pounds and his height was 72 inches tall with a BMI of 31.1 with preferences for large portions. R33's Clinical Nutrition Evaluation dated 9/22/24, indicated a height of 75 inches and the most recent weight of 230 pounds was from 8/4/24. Under the heading, "Supplements" indicated, "NA". Further, under the heading, "Skin Condition" indicated "No skin issues noted" and R33 preferred large portions. R33's nurse practitioner noted dated 9/16/24, indicated R33 had bilateral foot pain specifically in the heels without breakdown in hands or heels. R33's PT notes dated 10/21/24, indicated R33 was given a heel float wedge to improve his ability to float heels if he did exercises or bed mobility on his own. Pillows required much re-adjusting to truly float heels. R33's progress notes were reviewed and indicated the following: 5/28/24 at 12:18 p.m., R33 did not have skin breakdown upon admission and presented with a poor appetite. 6/12/24, physician note indicated R33 had a poor appetite. 9/19/24, at 8:52 a.m., R33 had an "unstated" pressure sore on the left heel and verbalized pain.	F 686		

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F 686	Continued From page 41 9/19/24 at 1:25 p.m., indicated nursing staff found an area of discoloration on the left heel and pressure injury interventions were initiated including heel boots and offloading while in bed and would be followed on wound rounds. 9/20/24 at 12:10 p.m., R33 was compliant with heel boots and floating heels. 9/26/24 at 1:42 p.m., R33 preferred floating heels with pillows versus boots and a risk versus benefits was on file. 10/4/24 at 3:11 p.m., monthly nutrition risk note from the dietary department indicated R33 had a stage one pressure ulcer on his heel with an effusion to the right knee, mild cognition impairment, muscle weakness, diabetes with a current weight of 219 pounds which was down from 230 pounds on 8/4/24. The note indicated R33 ate 100% and preferred large portions. Large portion and double meat would be added, would offer a sandwich at bedtime, and would monitor and document meal intakes and obtain weights per policy. The note lacked documentation R33 was provided Glucerna or equivalent per facility protocol, Juven or Prosource 30 milliliters by mouth twice daily. 10/10/24 at 1:43 p.m., R33 preferred floating heels with pillows rather than boots. 10/15/24 at 11:15 a.m., R33 stated he did not like his mattress because it made him uncomfortable and was agreeable to an air pressure reducing mattress. 10/17/24 at 1:22 p.m., R33 remained non compliant with heel boots and preferred offloading with pillows. R33's progress notes were reviewed and lacked documentation R33 refused repositioning, or supplements. A dietary progress note was later added on 10/24/24 at 10:17 a.m., that indicated R33 had refused supplements in the past and	F 686		

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F 686	Continued From page 42 originally when asked that morning, but was later willing to try. R33's Risk vs Benefits Form signed on 9/24/24, indicated R33 had limited compliance with repositioning with grab bars, floating heels, offloading pressure to backside, not wanting to be in the wheelchair, preference to lie flat on back in bed, and using heel boots. The form identified risk of non compliance included worsening or new skin breakdown, increased weakness, and muscle wasting. R33's Task Offload Heels with Heel Boots at all Times in Bed form dated 9/19/24, through 10/24/24, indicated R33 refused to offload his heels 7 times. R33's Behavior Task form dated 9/25/24, through 10/24/24, indicated R33 refused cares one time. R33's Amount Eaten Task form dated 8/26/24, through 10/24/24, indicated R33 refused meals 57 times. Further, R33 ate 0-25% of meals 6 times, 26-50% of meals 35 times, 51-75% of meals 41 times, and 76-100% of meals 20 times. R33's IDT Care Conference form dated 7/17/24, indicated dietary had no concerns. Further, R33 required significant assist with activities of daily living and was a poor participant in therapy. R33's IDT Care Conference Form dated 9/22/24, and locked on 10/8/24, indicated dietary had no new concerns and R33's weight was stable. The form lacked documentation regarding R33's left heel wound. R33's IDT Care Conference Form dated 9/30/24,	F 686		

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F 686	Continued From page 43 and locked on 10/9/24, indicated nursing had no concerns but had a healing wound on foot. Under the heading Dietary, indicated R33's weight was stable and had no changes. R33's weight was documented as 219 pounds. The dietary director portion of the note was signed by the facility administrator on 9/30/24. Social services indicated R33 had intact cognition. The other team members and family in attendance included R33, nursing, and R33's family member. R33's Weekly Skin Inspection form dated 9/11/24, indicated R33's skin was normal in color with minimal dryness noted on the feet and no notable issues or concerning changes observed. R33's Weekly Skin Inspection form dated 9/19/24, indicated R33 had a new alteration in skin integrity on the heel and skin prep was applied to the heels and feet were floated. R33's Weekly Skin Inspection form dated 10/2/24, indicated R33 continued with optimal skin with only mild dryness that was apparent on both feet and no new skin issues were noted. R33's Weekly Skin Inspection form dated 10/9/24, indicated R33's skin was "good & healthy in color. Pt have an abrasion wound on the left heel that is follow every week by a wound clinic." Further, the note indicated there were no significant skin issues observed. R33's Weekly Skin Inspection form dated 10/16/24, indicated R33's skin was documented as, "Intact". R33's Weekly Skin Inspection form dated 10/23/24, indicated R33's skin was "good &	F 686		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 44	F 686		

healthy in color. Pt have an abrasion wound on the left heel that is follow every week by a wound clinic." Further, the note indicated there were no significant skin issues observed.

R33's Skin and Wound Evaluation form dated 9/19/24, indicated R33 had a new facility acquired stage one pressure ulcer to the left heel. The exact date was not documented in the form. The wound measured 4.6 cm long by 3.6 cm wide with no eschar to the wound bed. Further, the note identified the wound as an intact blister. The note lacked information whether the wound the healable. Additionally, under a heading, "Additional Care", identified check boxes next to mobility aid(s) provided, nutrition/dietary supplementation, positioning wedge, repositioning devices, and turning and repositioning program. Under the heading, "Notifications" identified check boxes next to practitioner notified. There were no checked boxes next to resident/responsible party notified, dietician notified, or therapy notified.

R33's Skin and Wound Evaluation form dated 9/26/24, indicated R33 had a stage one pressure ulcer to the left heel that measured 5.6 cm long by 3.4 cm wide. The wound bed was documented as intact unbroken skin and did not identify whether the wound was healable. Additionally, under a heading, "Additional Care", identified check boxes next to mobility aid(s) provided, nutrition/dietary supplementation, positioning wedge, repositioning devices, and turning and repositioning program. The wound progress was documented as stable. Under the heading, "Notifications" identified check boxes next to practitioner notified. There were no checked boxes next to resident/responsible party

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F 686	Continued From page 45 notified, dietician notified, or therapy notified. R33's Skin and Wound Evaluation form dated 10/2/24, indicated R33 had a stage one pressure ulcer to the left heel that measured 6.1 cm long by 5.3 cm wide. Further, the note identified the wound as an intact blister. Additionally, under a heading, "Additional Care", identified check boxes next to mobility aid(s) provided, nutrition/dietary supplementation, positioning wedge, repositioning devices, and turning and repositioning program. The wound progress was documented as stable. Under the heading, "Notifications" identified check boxes next to practitioner notified. There were no checked boxes next to resident/responsible party notified, dietician notified, or therapy notified. R33's Skin and Wound Evaluation form dated 10/10/24, indicated R33 had a stage one pressure ulcer to the left heel that measured 5.9 cm long by 3.4 cm wide. The wound was filled with 50% eschar tissue and was identified as an intact blister. Additionally, under a heading, "Additional Care", identified check boxes next to mobility aid(s) provided, nutrition/dietary supplementation, positioning wedge, repositioning devices, and turning and repositioning program. The wound was documented as improving. Under the heading, "Notifications" identified check boxes next to practitioner notified. There were no checked boxes next to resident/responsible party notified, dietician notified, or therapy notified. R33's Skin and Wound Evaluation form dated 10/17/24, indicated R33 had a stage one pressure ulcer to the left heel that measured 3.6 cm long by 4.1 cm wide. The wound bed was	F 686		

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F 686	Continued From page 46 filled with 100% eschar tissue. Additionally, the heading, "Additional Care", identified a check box next to air flow pad and the wound was documented as improving. The "Notifications" heading indicated there were no checked boxes next to practitioner, resident/responsible party notified, dietician notified, or therapy notified. R33's nurse practitioner (NP)-A wound consult note dated 9/19/24, indicated R33 had a stage one pressure ulcer to the left heel and R33 weighed 230 pounds. The note further indicated the nurse manager was to supply prevalon boots for additional offloading and encouraged aggressive offloading and repositioning, good diabetes control, and proper nutrition and hydration. Under a heading, "Plan" indicated R33 had multiple comorbidities that affected wound healing and wound progression including diabetes mellitus type two, limited mobility, muscle weakness, and risk for malnutrition. Additionally, the note indicated R33 was at risk for malnutrition and suggested supplementation with Glucerna or equivalent per facility protocol, Juven or Prosource 30 milliliters by mouth twice daily, and suggested following a dietician as needed. Additionally, under the heading, "Plan", R33 required skin prep to the heel and allow to dry, boots and float heels freely and offload and reposition. The current diagnoses portion of R33's note indicated R33 had unspecified protein-calorie malnutrition. R33's NP-A wound consult note dated 9/26/24, indicated a stage one pressure ulcer to the left heel and R33 weighed 219 pounds. Further, R33 was alert and oriented and was able to make his needs known. NP-A encouraged aggressive offloading and repositioning, good diabetes	F 686		

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F 686	Continued From page 47 control and proper nutrition and hydration. The heading, "Plan" indicated R33 had multiple comorbidities that affected wound healing and wound progression including diabetes mellitus type two, limited mobility, muscle weakness, and risk for malnutrition. Additionally, the note indicated R33 was at risk for malnutrition and suggested supplementation with Glucerna or equivalent per facility protocol, Juven or Prosource 30 milliliters by mouth twice daily, and suggested following a dietician as needed. Additionally, under the heading, "Plan", R33 required skin prep to the heel and allow to dry, boots and float heels freely and offload and reposition. The current diagnoses portion of R33's note indicated R33 had unspecified protein-calorie malnutrition. R33's NP-A wound consult note dated 10/2/24, indicated a stage one pressure ulcer to the left heel and R33 weighed 219 pounds. The note indicated R33 had an intact blood blister on the left heel. The heading, "Plan" indicated R33 had multiple comorbidities that affected wound healing and wound progression including diabetes mellitus type two, limited mobility, muscle weakness, and risk for malnutrition. Additionally, the note indicated R33 was at risk for malnutrition and suggested supplementation with Glucerna or equivalent per facility protocol, Juven or Prosource 30 milliliters by mouth twice daily, and suggested following a dietician as needed. Additionally, under the heading, "Plan", R33 required skin prep to the heel and allow to dry, boots and float heels freely and offload and reposition. The current diagnoses portion of R33's note indicated R33 had unspecified protein-calorie malnutrition.	F 686		

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F 686	Continued From page 48 R33's NP-A wound consult note dated 10/10/24, indicated a stage one pressure ulcer to the left heel and R33 weighed 219 pounds. The note indicated the blister was getting smaller and the wound edges remained "eschar". The heading, "Plan" indicated R33 had multiple comorbidities that affected wound healing and wound progression including diabetes mellitus type two, limited mobility, muscle weakness, and risk for malnutrition. Additionally, the note indicated R33 was at risk for malnutrition and suggested supplementation with Glucerna or equivalent per facility protocol, Juven or Prosource 30 milliliters by mouth twice daily, and suggested following a dietician as needed. Additionally, under the heading, "Plan", R33 required skin prep to the heel and allow to dry, boots and float heels freely and offload and reposition. The current diagnoses portion of R33's note indicated R33 had unspecified protein-calorie malnutrition. During interview and observation on 10/21/24 between 6:32 p.m., and 6:39 p.m., R33 stated he had a smaller bed prior to this date and his foot used to touched the foot board and stated had received an air mattress today. R33 had a heel flotation cushion in bed under his legs, but the left heel was still touching the mattress. R33 had dryness around the left heel with flaking dry skin and a round blackened area was observed on the back of R33's left heel approximately the size of a tennis ball. R33 stated they put ointment on the area and tried to put a boot on his feet but stated it rubbed and told staff he did not want the boot because it was hurting his heel. During interview and observation between 10/22/24 at 10:01 a.m., and 10:07 a.m., R33 continued to have a thick blackened area to the	F 686		

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F 686	Continued From page 49 left heel and when R33 was relaxed, the foot touched the bed. R33 had a heel flotation cushion positioned under the left leg. Additionally, R33 had a low air loss APM 48 inch air mattress that indicated was from Integra Healthcare. The weight setting indicated all green lights were lit including up to 660 to 750 pounds. A green light was located on alternate and a 10 minute cycle. R33 stated he was 6 feet, 3 inches tall and weighed about 215 pounds. During observation 10/23/24 between 8:19 a.m., and 8:23 a.m., NA-D brought R33 his breakfast and took off the cover on R33's plate, and R33 had a small scoop of eggs and toast with no other items on the breakfast tray. R33's meal ticket indicated R33 required a regular diet with large portions. At 8:23 a.m., NA-A entered R33's room and asked R33 if he was going to eat his breakfast and R33 stated he was not. NA-A asked R33 why he was not going to eat and R33 stated because he had no meat on his tray. NA-A repeated that R33 stated no meat and walked out of the room. NA-A did not offer repositioning and did not offer to provide meat. During interview on 10/23/24 at 8:27 a.m., NA-A stated residents don't receive meat every day and did not know if residents could get meat if they asked for it and stated she would get on the phone and ask the kitchen. NA-A further stated R33 wasn't going to eat because there was no meat and he didn't ask for meat. After inquiry, NA-A went into R33's room and asked R33 what he would like and stated she would let them know R33 wanted sausage every day. During interview on 10/23/24 from 8:31 a.m., to 8:38 a.m., LPN-A stated she would have	F 686		

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F 686	Continued From page 50 expected the NA to offer an alternative per R33's preference after resident stated there was no meat. When asked what was on R33's plate, LPN-A stated R33 had a scoop of eggs and 2 pieces of toast. At 8:34 a.m., LPN-A unplugged R33's bed and plugged the bed into another outlet behind the bedside table and brought the breakfast out of the room. LPN-A did not look at the settings on the bed, and then called and asked kitchen to bring up a peanut butter and jelly sandwich. At 8:37 a.m., staff brought sausage to R33. At 8:38 a.m., NA-A brought R33's plate into the nursing station to warm up the meal in the microwave. During interview on 10/23/24 at 8:40 a.m., the dietary director (DD) stated R33's plate looked a bit light when asked about the large portions. NA-A told DD she just mashed the eggs up to warm them and told DD there was only one scoop of eggs on the plate for R33. During interview and observation on 10/23/24 at 8:45 a.m., LPN-A viewed R33's air mattress settings, verified they were set for 660 to 750 pounds, and stated the weight setting was incorrect. NPN-A asked R33 how much R33 weighed, readjusted the settings, and stated she would be back to double check after verifying R33's weight. During interview on 10/23/24 at 8:54 a.m., the dietician stated she worked at the facility one day a week and completed all high risk documentation. The dietician stated residents at high risk included residents with weight loss, tube feedings, and wounds, and she could run reports for wounds and if staff reached out with concerns. The dietician further stated if a resident had a	F 686		

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F 686	Continued From page 51 wound and had a good appetite, she may do double proteins if they were not malnourished, looked at protein intake, and stated if supplements were needed she would make a progress note or put an order in the chart. The dietician stated she was alerted if a resident had a wound right away and expected staff to inform her right away. The dietician stated R33's appetite was good and his weight was stable and would expect large portions, and stated R33 was educated if he wanted larger portions could let staff know. She further stated R33 only had a stage one pressure ulcer, but if he had more than a stage one pressure ulcer, R33 would definitely need more protein. When asked about R33's weights, the dietician stated R33's weights were stable for the last two months at 217 to 219 pounds and prior to that was 230 pounds upon admission. The dietician stated R33 was not triggering for significant weight loss for some reason and could not identify why R33 lost weight. The dietician further stated R33's appetite was variable and he had been eating 100%, and stated a double protein would be a double scoop of the eggs, and she could talk with dietary staff about resident not receiving double proteins. During interview on 10/23/24 at 9:53 a.m., LPN-A stated R33 would be on their wound rounds on 10/24/24. During interview on 10/23/24 at 1:31 p.m., family member (FM)-B stated R33's mattress was changed but was not sure when because the facility did not communicate well regarding R33's care. FM-B further stated the facility never informed FM-B when R33 developed a pressure ulcer. FM-B stated R33 was a bigger man and	F 686		

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F 686	Continued From page 52 needed a bigger bed, and at first the facility was not supplying a longer bed. FM-B stated R33 was 6 feet, 5 inches tall and asked about R33 having a bigger bed after R33 developed a pressure ulcer. FM-B stated she would door dash food for R33 and stated R33 was a bigger man and wanted double portions, but the facility provided traditional portion sizes, and added R33 had diabetes and stated they should be extra cautious with R33's food due to blood flow so his foot would not be amputated. During interview on 10/23/24 at 2:04 p.m., LPN-A stated NP-A was conducting wound rounds on 10/24/24. LPN-A refused to allow visualization of wound images in the electronic medical record (EMR). LPN-A stated wounds were documented under the Forms tab in the EMR and stated the first pictures taken were on 9/19/24, and she was notified on 9/19/24, R33 had a pressure ulcer, added him to the list for wound rounds, and he was seen the same day. LPN-A further stated the provider stated the wound was a pressure ulcer, but did not tell LPN-A what caused it. LPN-A stated R33 was at risk for pressure ulcer development prior to R33 developing a pressure ulcer. LPN-A stated interventions in place to prevent pressure ulcers included monitoring skin during daily cares, and all beds had pressure redistribution mattresses and cushions on all beds. LPN-A stated the air mattress was provided after R33 developed the wound but could not state when R33 received an air mattress, and stated they contracted with Integra. LPN-A stated R33's wound started as a stage one pressure ulcer and if the NP documented R33 had a blister, she would defer to the NP's documentation and stated categorizing and labeling wounds was left up to the NP wound care	F 686		

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F 686	Continued From page 53 providers. During interview with the DON and administrator on 10/24/24 at 7:50 a.m., and 8:00 a.m., the DON stated the wound provider took all the wound pictures and filled out and documented on the form under skin and wound evaluation. The DON further stated, under the miscellaneous tabs, the NP uploaded the individualized wound notes and the DON completed a skin and wound note weekly in the progress notes and stated R33 had wound notes on 9/26/24, 10/2/24, 10/10/24, and 10/17/24. DON stated they provided R33 with an air mattress on 10/21/24. The administrator added R33 felt the mattress was too firm and had less to do with R33's skin. They were comfortable with leaving R33 with interventions for grab bars and floating heels, and stated R33 was non compliant with boots and preferred pillows for interventions because the boots were uncomfortable. At 8:00 a.m., the administrator stated they switched to Integra and did not have a user manual for the air mattress. The DON stated their root cause analysis found R33 got the pressure ulcer from being stationary in bed and R33 lays flat on his back in bed with his heels on the mattress. During interview on 10/24/24 at 8:05 a.m., LPN-G stated they measured residents with a tape measure while the resident was in bed. During interview on 10/24/24 at 8:13 a.m., the dietician stated R33 was not on any supplements and stated she should have written protein and not meat and corrected the ticket because the meal ticket indicated double something. When asked about a handbook they utilized for wound treatment guidelines, the dietician stated they	F 686		

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F 686	Continued From page 54 treated residents individually and depending on whether a wound was healing or what stage it was, a resident may not need an additional protein. She added it was very individualized and stated that obviously, if a wound was a stage three or stage four she would put in Prosource. The dietician stated she was just going to go in and visit with R33 at this time. During interview on 10/24/24 at 8:42 a.m., the general manager (GM) from Integra stated the air mattress provided adequate wound therapy when they put it close to the weight setting. A copy of the user manual was requested. During interview on 10/24/24 at 9:14 a.m., the certified occupational therapy assistant (COTA) program director stated OT was not working with R33 currently and R33 was currently only working with physical therapy. COTA stated R33 had a heel sore and required an EZ stand mechanical transfer, and in order to use the EZ stand, R33 had to bear weight on both heels. COTA stated she assumed R33 got the pressure ulcer from being in bed with his heels on the mattress, and there was an intervention to start elevating heels so they did not touch the mattress. COTA stated R33 was a reliable historian and made accurate statements. Further, COTA stated the therapists did a good job documenting when and if they initiated a wedge cushion in bed. COTA reviewed therapy notes and stated the first mention of the wedge was on 10/21/24, when R33 was provided a heel float wedge to improve R33's ability to float heels. The note indicated the pillows required much readjusting to truly float and stated the wedge was provided on 10/21/24. During interview on 10/24/24 at 9:36 a.m., LPN-G	F 686		

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F 686	Continued From page 55 stated he measured R33 who was 6 foot 3 inches. During interview on 10/24/24 10:02 a.m., R33 was in bed and the mattress weight settings were set at 220 pounds. There resident stated his bed was comfortable and felt it was not too soft or too firm. R33 stated he could feel the air circulating in the bed yesterday but not now. R33's bed was firm and air was in the bed. During interview on 10/24/24 10:30 a.m., the director of quality and compliance from Integra stated he assumed, the air mattress should be set according to a person's weight because it had that setting for a reason, and therapy may not be delivered as competently if weight was set at a different setting. During interview and observation on 10/24/24 at 11:55 a.m., NP-A stated she did not measure wounds manually and had a, electronic measurements application. NP-A stated the wound measured 2.4 cm long by 4.4 cm wide, was fully covered by eschar tissue, and stated the wound was not stageable because it had eschar. NP-A stated R33 got the wound from pressure and stated it started as a blister, they did not know how deep the wound was, stated the wound was healable, and R33 was very compliant with offloading and freely floating it. NP-A stated the wound was always preventable. Further, the NP stated they suggested supplementation if R33 had weight loss, did not know how much weight R33 lost, and stated they could have looked more at R33's nutrition as it could have helped more with wound healing. NP-A stated R33's risk factors included immobility and unspecified malnutrition, and it was important for R33 to	F 686		

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F 686	Continued From page 56 receive larger portions because R33 was a bigger man. NP-A further stated the wound started as a blister and she did not want the heel touching the bed at all, and stated it needed to float to relieve pressure and was 100% covered in eschar. R33 stated his wound was caused from his foot hitting the wood of the foot of the bed. NP-A stated it started as an intact and dried blister and was now eschar and she could not stage it, and further stated a blister should not be staged as a stage two because the skin had to have been broken open and it never did. NP-A stated she did not know what weight settings on the air mattress indicated or specifics whether weight was set at the incorrect setting. During interview on 10/24/24 at 12:11 p.m., the DON stated a stage one pressure ulcer was intact skin with nonblanchable (rashes that do not disappear with pressure) redness, and the NP was the person who staged R33's pressure ulcer. DON stated she could refer to their pressure ulcer staging policy when asked what a stage two pressure ulcer was and did not want to attest to what NP-A was documenting for her staging, but stated if a wound was fully covered with eschar, it would be unstageable. The DON further stated they used different treatments for a stage one pressure ulcer versus a stage four and stated she would provide staging policies. When asked how they know a wound has improved when the wound was covered in eschar, the DON stated it was intact and measurements decreased. Further, the DON stated if a resident had substantial weight loss or malnutrition, the dietician offered a protein supplement. In addition, DON stated they completed staff education on floating heels, R33 signed a risk versus benefits form, and they are utilizing the	F 686		

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F 686	Continued From page 57 pillows and the wedge. During interview on 10/24/24 at 2:37 p.m., the DON verified R33 refused several meals. Requested items included a 60-day look back report, and repositioning and behaviors tasks, but was not provided a task on repositioning. A policy, Skin Assessment and Wound Management, revised March 2024, indicated the purpose of the policy was to provide guidelines for assessment and managing wounds. Additionally, the policy indicated a pressure ulcer risk assessment (Braden Scale) would be completed, implement appropriate preventative skin measures. Examples include but are not limited to nutritional interventions, mobility and repositioning plan, pressure redistribution plan, skin evaluation and skin risk factors form is completed before the initial MDS, annually, and upon significant change, staff will perform routine skin inspections, nurses are to be notified if skin changes are identified, a weekly skin inspection will be completed by a licensed staff. For pressure wounds, the policy indicated when a pressure ulcer is identified, the following actions will be taken: notify the provider/treatment ordered, notify resident representative, complete education with resident/resident representative including risks and benefits, initiate skin and wound evaluation, notify nurse manager wound nurse, referral to dietary, if appropriate, referral to therapies if appropriate, review and update care plan including interventions, update resident care lists, update care plan to identify risks for skin breakdown. The policy lacked information on how to correctly stage pressure ulcers, determining appropriate risk related to sensation or pigment of skin, or identify when a referral to	F 686		

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F 686	Continued From page 58 dietary or therapies would be appropriate.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure an occupational therapy (OT) ordered hand splint program was implemented for 1 of 2 residents (R14) reviewed for positioning and mobility. Findings include: R14's quarterly Minimum Data Set (MDS) dated 10/3/24, identified he could understand with clear comprehension and could be understood. The cognitive assessment was not completed. Diagnoses included hemiplegia (paralysis and weakness) affecting right dominant side and	F 688	1. R14 received an occupational therapy (OT) evaluation for his hand splint. R14 remains on OT ongoing for working on a proper hand splint. OT will complete nursing communication form once a proper splint device has been identified. Previous splint order and care plan are now resolved. 2. All residents with a upper extremity range of motion deficit has the potential to be affected. These residents were reviewed with the therapy director to determine the need for therapy screens	11/20/24

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F 688	Continued From page 59 muscle weakness. Extensive assistance of two staff was required for bed mobility. R14's quarterly MDS's dated 10/3/24, 8/13/24, and 5/16/24, identified no rejection of care and no days of restorative splint or brace assistance occurred. R14's activities of daily living (ADL) Care Area Assessment (CAA) dated 2/27/24, was triggered due to extensive assist of one to two staff for bed mobility, toileting, dressing, and personal hygiene, and total assist with two staff for Hoyer transfers was required. R30 was non-ambulatory and was at risk for further decline in ADL's, falls, contractures, further isolation, and complications of immobility: pressure ulcers, muscle atrophy, incontinence, and contractures. Proceed to care plan to prevent/minimize risks; work with resident to maintain current level of functioning. R14's care plan dated 10/10/24, identified he required the use of a splint for his right hand for positioning and contracture management. Goals include to wear the splint on the right hand for 15 minutes/24 hours or to tolerance to prevent contractures/increase PROM (passive range of motion), decrease pain, reduce muscle tightness, and allow participation in ADL's. Interventions included: 1. Check for skin breakdown under right hand brace 2. PROM exercises 3. Resident refuses to wear splint as it is uncomfortable. Therapy to follow up to indicate if bracing is still indicated. 4. Resident splint: unless medically contraindicated don splint or brace by putting thumb in first and spinning to don. Don/doff per	F 688	for splints, devices, or ROM programs to prevent further contractures/ADL decline. Care plans and orders updated as needed. 3. Education provided to all nursing staff on residents with upper extremity range of motion deficits that have interventions care planned. The importance of documenting refusals and changes of condition. The facility ADL policy was reviewed and remains current. 4. The director of nursing and/or designee will complete a weekly audit of 3 random residents to ensure that restorative nursing interventions are in place if they have a care planned intervention for 4 weeks. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 688	Continued From page 60 schedule and as tolerated. Observe skin for complication related to use every shift and with each removal and application. Observe and report pain, offer medication as needed. R14's OT note dated 10/16/23, identified R14 declined use of previous right wrist splint, and said it rubbed on his hand and fingers and hurts to wear it for any length of time. OT modified palm guard by inserting red foam roll to provide some prolonged pressure and slow stretch into his right hand. The resident did report that this felt better than the splint as it did not rub nearly as much. OT placed in hand and checked after 2-3 hours for use with no increased pain noted by the resident. R14's OT discharge summary dated 10/26/23, identified the goal was met for hand roll splint toleration wearing schedule of six to eight hours daily to prevent further contracture of his right fingers, hand, and wrist. Staff demonstrated ability to don and doff right palm guard with hand roll. Discharge recommendations the identified splint/brace (palm guard with roll) prognosis was good if staff consistently followed through. R14's progress notes dated 10/23/23 through 10/24/24, lacked documentation he refused the OT recommended hand splint program. R14's Treatment Administration Record (TAR) dated 6/1/24 through 8/31/24, identified an order with start date of 11/23/23, to place brace (splint) after moving hand and all fingers within resident's tolerance of movement. The order was check marked as having been completed daily by nursing before being discontinued on 8/26/24.	F 688		

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F 688	Continued From page 61 R14's order discontinuation summary dated 8/26/24, identified the above brace order from the TAR was discontinued and the section for reason for discontinuation was left blank. There was no rationale for stopping the splint. R14's care conferences dated 8/9/24 and 10/8/24, lacked a discussion about the hand splint or contracture. During an observation and interview on 10/21/24 at 6:54 p.m., R14 was in bed. A hand roll splint was on top of his bedside table. When asked about the splint, R14 stated his right hand could not be opened anymore. R14 used his left hand to uncover his right hand from the sheet, his right hand was observed to be contracted in a fist position. There was also an unpleasant odor to his right hand. R14 said the hand roll splint was for his right hand but it was too painful to wear. During an observation on 10/22/24 at 8:11 a.m., R14 was in bed without the splint on. During an interview on 10/22/24 at 1:38 p.m., nursing assistant (NA)-A stated therapy would tell the staff if a resident had a splint program. NA-A stated she had worked at the facility for a year and was not aware of R14's splint program. NA-A agreed R14's hand was contracted into a fist position. During an interview on 10/22/24 at 1:40 p.m., trained medication assistant (TMA)-A stated R14 used to have a splint, but he had not seen it. TMA-A reviewed the orders and said there were no current orders for it. If the order was active it would show up for nursing to check off upon the order's completion.	F 688		

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F 688	Continued From page 62 During an interview on 10/22/24 at 1:43 p.m., the certified occupational therapist assistant (COTA) reviewed R14's therapy medical record and stated he was seen for right hand contracture last year from 7/2023 until 10/26/23. Therapy worked with him on ROM (range of motion) and slow stretch to make donning of palm guard easier. R14 was discharged from therapy with orders for scheduled hand roll splint 4-6 hours daily to prevent further contracture, teach nurses and update care plan and upon discharge teaching, staff were able to demonstrate the don and doff process. The COTA stated therapy was not updated the hand roll splint was no longer implemented as intended and would expect nursing to follow up so they could reassess as that process was usually part of the training provided to nurses when a splint program was implemented. The COTA stated there were not measurements of the contracture on file, so she was unable to determine if the contracture had worsened without the splint program implementation. Additionally, contractures could cause pain and contribute to skin breakdown, especially in the palm due to moisture and pressure. During an interview on 10/22/24 at 1:55 p.m., registered nurse (RN)-B stated if a resident had a splint, there should be an order in place. RN-B stated if splint interventions were in the care plan they should be implemented, if the resident was not using the splint, therapy should be updated so a reassessment could be started. During a follow up interview on 10/23/24 at 1:30 p.m., R14 was sitting up in his wheelchair. There was no odor to his hand. He stated staff have not	F 688		

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F 688	Continued From page 63 offered the hand splint and he said he probably could not tolerate it due to the discomfort. During an interview on 10/22/24 at 2:07 p.m., the director of nursing (DON) reviewed R14's splint care plan and agreed the last update coinciding with the MDS was on 10/10/24, so the care plan was up to date. The DON stated the care plan identified he refused the splint, however, was not able to answer when asked if therapy followed up in accordance with the care plan. During a follow up interview on 10/24/24 at 11:34 a.m., with the DON and administrator together, the DON stated contractures posed a risk for skin breakdown and pain and after reviewing the medical record did not see a rationale why R14's splint was discontinued on 8/26/24. The DON stated the checkmarks after the order on the TAR identified the program was carried out as ordered up until it's discontinuation date. The administrator stated R14 was cognitively intact and could speak for himself and had refused the splint. When asked for documentation of refusals, or a conversation with R14 on risks of not wearing a splint and the options of a reassessment with therapy, none was provided. During a follow up observation and interview with R14 on 10/24/24 at 11:59 a.m., he stated nursing staff put a rolled-up washcloth in his hand today as they were worried his fingernails would cut into his palm, he also stated his skin can get "iffy" since his hand was stuck closed, and he did not want more problems. The DON walked by R14's room and was called in to observe the washcloth and R14 stated it felt good, he had it on for about one hour now without pain.	F 688		

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F 688	Continued From page 64 An assistive device and/or splint program policy was requested and not provided. The facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities dated 3/31/23, identified based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility would provide the necessary care and services to ensure that a resident's abilities in activities of daily living did not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement fall interventions for 1 of 2 residents (R40) reviewed with a history of falls. Findings include: R40's admission Minimum Data Set (MDS) dated 9/8/24, indicated R40 had intact cognition, did not reject cares, had a walker, required partial to moderate assist with toileting, showering and lower body dressing, required supervision for transfers from chair to bed, required partial to	F 689	1. R40s fall intervention care plan was reviewed and the use of skid tape was resolved, because R40 is able to avoid slippage with the use of gripper socks. Resident is compliant with gripper socks and has had no further falls. Care plan and care guide updated for R40. 2. All residents with current fall interventions have the potential to be affected. All residents with fall care plans were reviewed, and fall interventions validated as being in place. Interventions	11/20/24

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F 689	Continued From page 65 moderate assist with toilet transfers, and did not have a history of falls. R40's Medical Diagnosis form undated, indicated the following diagnoses: heart failure, muscle weakness, difficulty in walking, neoplasm of unspecified behavior of brain, malignant neoplasm of unspecified part of the right bronchus or lung, and metabolic encephalopathy (a change in how the brain works). R40's physician orders indicated the following order: 10/11/24, apixaban (an anticoagulant) oral tablet 5 milligram (MG) give 1 tablet by mouth two times a day related to atrial fibrillation (irregular, fast heart beat). R40's care plan dated 9/3/24, indicated R40 was at risk for falls due to osteoarthritis and had the following interventions in place: physical therapy (PT) per physician orders, follow PT and occupational therapy (OT) instructions for mobility function, low bed, keep room clean and free of clutter, keep call-light in reach, and monitor and document on safety. Review information on past falls and attempt to determine the cause of falls, record possible root causes, alter or remove any potential causes if possible, educate the resident, family, caregivers, and interdisciplinary team (IDT) as to causes. The care plan lacked interventions for applying non-slip tape to R40's room. Further, R40's care plan indicated R40 required assist of one for ambulation. R40's care guide indicated R40 was assist of one with activities of daily living (ADLs) and required stand by assist with ambulation. The care guide lacked information for fall prevention	F 689	that are no longer effective have been resolved from resident care plan and care guide. 3. All nursing staff educated on where to locate fall interventions on the care guide as well as the care plan, and the importance of ensuring that all care planned interventions always remain in place. 4. The Director of nursing and/or designee will complete 4 audits weekly of 4 random residents to ensure that fall interventions are in place for 4 weeks. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 689	Continued From page 66 interventions. R40's nursing progress note dated 10/3/24 at 7:42 a.m., indicated R40 was found on the floor around 5:45 a.m., on her left side and R40 stated she was trying to go to the bathroom and slipped. R40's interdisciplinary team (IDT) note dated 10/3/24 at 4:10 p.m., indicated R40's fall was reviewed by the IDT and indicated upon return from the hospital, R40 would have gripper socks at nighttime, and non-slip tape on the bedroom floor. R40's Fall Review Evaluation Updated form dated 10/3/24 at 4:18 p.m., indicated R40 had a recent fall, and under a heading, "Summary/Interventions" indicated R40 was sent to the hospital for further evaluation and upon return would be encouraged to wear gripper socks at night and would have non-slip tape placed on the floor in R40's room. R40's IDT note dated 10/23/24 at 12:20 p.m., indicated IDT reviewed R40's fall interventions and universal fall precautions remained in place, R40 was stable with gripper sock intervention following recent fall and planned to resolve non-skid tape on R40's floor. R40's history and physical dated 10/3/24 at 5:43 p.m., indicated R40 had a history of Alzheimer's disease, small cell lung cancer (SCLC) that progressed to a stage four with brain metastasis in February 2023, ischemic cardiomyopathy, and coronary artery disease and was unable to identify when she fell, or provide a history. The history and physical further indicated R40 fell on 10/3/24 at 5:00 a.m., and hit the left side of her	F 689		

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F 689	Continued From page 67 head and her left hip. During observation on 10/21/24 at 2:09 p.m., R40 had a faded bruise located on R40's left cheekbone. R40 had a walker at the bedside with two hand rails on the bed. During observation on 10/22/24 at 9:47 a.m., R40's floor lacked non-slip tape. During observation on 10/23/24 at 10:40 a.m., R40's floor lacked non-slip tape. During interview on 10/23/24 at 11:01 a.m., nursing assistant (NA)-A stated R40 went to the bathroom independently and added R40 didn't bother them and thought R40's family member put R40's clothes out. During interview on 10/23/24 at 11:16 a.m., registered nurse (RN)-A stated they looked at the care plan and a Kardex to know what kind of cares a resident required and stated R40 would walk in the room independently. R40 repeated the same questions, asking how she wore her compression stockings. RN-A stated an intervention for non-slip tape was documented in the progress notes and RN-A verified R40's room lacked non-slip tape and stated it was important to have the intervention in place to reduce the risk of R40 falling. During interview on 10/23/24 at 11:39 a.m., the director of nursing (DON) stated NA's documented in the electronic medical records (EMR) and used care guides to know what cares a resident required. The DON further stated every resident had universal fall precautions in place including occupational therapy (OT),	F 689		

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F 689	Continued From page 68 physical therapy (PT), keep the call light in reach, low bed, keep the room free of clutter, and were in place prior to R40's fall and they monitored for bruising because R40 was on an anticoagulant. The DON viewed R40's note dated 10/3/24, that indicated R40 would have non-slip tape on the bedroom floor and stated it was a double intervention, R40 was forgetful and not always compliant and stated tape would be a further intervention. A policy, Fall Prevention and Management, dated February 2024, indicated the facility identified residents at risk for falls, implemented fall prevention interventions, provided guidelines for assessing a resident after a fall and assisted staff in identifying causes of the fall. Staff may also identify and implement relevant interventions to try to minimize serious consequences of falling. Staff will clarify the details of a fall and the IDT will review falls at a.m. meetings and document interventions, first aid, or treatment, and care plans will be updated to reflect fall interventions.	F 689		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		11/20/24

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	245083	A. BUILDING _____ B. WING _____	C 10/24/2024

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THE VILLAS AT THE PARK	4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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F 880	Continued From page 69 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 70 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized enhanced barrier precautions (EBP) during wound care and failed to ensure current standards of infection control practice for catheter care was followed for 1 of 2 residents (R30) observed for wound care and catheter care. Findings include: EBP R30's quarterly Minimum Data Set (MDS) dated 9/24/24, identified she had intact cognition, and no behaviors or rejection of care occurred in the lookback period. Diagnoses included stress incontinence and neurogenic bladder. Currently, two unstageable pressure injuries presenting as deep tissue injury were present and R30 had an indwelling catheter. R30 required extensive assist of two staff for bed mobility, transfers, and toilet use. R30's care plan dated 9/11/24, identified EBP	F 880	1. R30s care plan and orders were reviewed for EBP and remain current. R30s care plan was updated to indicate placing barrier on floor and use of an alcohol wipe at catheter drainage site after output for infection prevention. 2. All residents with a wound or catheter have the potential to be affected. Care plans for like residents were reviewed and updated to reflect use of a barrier on the floor and alcohol wipes to be used at drainage output site for catheter. As well as having current orders and care plan for EBP. Nurse leadership verified the placement of a proper EBP sign and supplies outside of identified resident rooms. EBP bins were reviewed, and alcohol wipe supplies placed in bins for residents with catheters to aid staff in proper catheter care. 3. All nursing staff educated on when to use EBP and why, as well as the proper	

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F 880	Continued From page 71 were in place due to foley catheter. Interventions included to follow EBP and don/doff PPE (personal protective equipment) when high contact cares were required. The care plan lacked EBP for wound care. R30's undated banner from the front page of the electronic medical record (EMR) identified "Special Instructions: Staff to follow enhanced barrier precautions R/T (related to) indwelling catheter and wounds." During an observation on 10/21/24 at 5:17 p.m., R30's bedroom door had an EBP sign on it and PPE bin directly outside the room entrance, containing gowns, gloves, and masks. The EBP sign directed staff to wear gloves and a gown for the following high contact resident care activities: dressing, bathing, transfer, hygiene, changing incontinence products, and device care including line care, catheter care, tubes, tracheostomy, and wound care. During an observation and interview on 10/22/24 at 10:24 a.m., registered nurse (RN)-B and RN-C walked past the PPE bin, entered R30's room, used hand sanitizer, and put gloves on. RN-B leaned over with scrub top touching R30's bed linens, removed the blanket off R30's right foot, unwrapped and removed dried bloody gauze wrap from the right foot pressure ulcer and right lower leg abrasion and disposed the dressing in the garbage can. The wounds were now open to air. RN-B changed gloves and started to spray wound cleaner on new gauze to clean the wounds. At this point surveyor asked RN-B if PPE was required. RN-B said, yes, she removed gloves, exited, got a gown out of the bin outside the room, donned the correct PPE and RN-C did	F 880	techniques for infection prevention with catheter cares. 4. The director of nursing and/or designee will complete 4 audits weekly of 3 residents wound care to observe that EBP was followed, and 2 residents with catheters to ensure that proper IP techniques with catheters cares are followed. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 880	Continued From page 72 the same. During a follow up interview on 10/22/24 at 1:55 p.m., RN-B stated she should have had a gown on during wound cares to prevent the spread of any germs before starting direct resident care for wound dressing changes but forgot. Catheter Care The Minnesota State Health Force Center of Excellence; Nursing Assistant Skill Video number 57 dated 9/26/19, identified to empty a urinary catheter drainage bag the following critical steps must be completed correctly: place a barrier on the floor, place a urine collection container on top of the barrier, remove the drainage outlet from the bottom of the bag, open the outlet and drain the catheter bag contents into the container, close the outlet and wipe the end of the tube and tube holder with an alcohol wipe. R30's care plan dated 8/9/24, identified the following interventions for catheter care: position catheter bag and tubing below the level of the bladder and away from entrance, monitor and document intake and output as per facility policy, monitor for s/sx (signs and symptoms) of discomfort on urination and frequency, monitor/document for pain/discomfort due to catheter, and monitor/record/report to MD (medical doctor) for s/sx UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. The care plan lacked infection control measures during emptying the	F 880		

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F 880	Continued From page 73 catheter. R30's nurse practitioner (NP) progress note dated 10/16/24, identified a history of UTI. During an observation on 10/23/24 at 10:35 a.m., nursing assistant (NA)-A, with gloves and gown on, placed a urinal on the floor, opened the bottom outlet of the catheter bag, emptied 1,000 milliliters (mL) into a urinal, closed the outlet, walked to the room's bathroom, emptied the urinal in the toilet, returned and reopened bottom outlet, drained another 250 mL, closed the outlet, walked to the bathroom, emptied the urine in the toilet. NA-A had not placed a barrier on the floor under the urinal and had not used an alcohol wipe to clean the bottom drainage outlet after draining. During a follow up interview on 10/23/24 at 10:55 a.m., NA-A stated she was not prepared to empty the catheter and should have used a barrier on the ground for urine drips and alcohol wipe to clean. R30's room lacked the needed supplies. During an interview on 10/23/24 at 11:50 a.m., NA-D stated when emptying a catheter, a barrier should be used on the floor and then clean the drainage outlet with alcohol wipe for infection control. During an interview on 10/24/24 at 11:11 a.m., the director of nursing (DON) stated she would expect staff to wear the required EBP PPE prior to active wound care and expected standards of practice to be followed during foley catheter care. The facility policy EBP dated 4/1/24, identified EBP referred to the use of gown and gloves for use during high contact resident care activities for	F 880		

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F 880	Continued From page 74 residents known to be colonized or infected with a MDRO (multidrug resistant organisms) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident care activities included: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing. The facility policy Indwelling Catheter Care Procedure dated 7/21/23, identified when emptying the catheter bag, don new gloves, uncap bottom outlet of bag, drain urine into measuring container, cleanse outlet with alcohol swab and recap the outlet. Measure urine and dispose of it in toilet. Remove gloves and wash hands. The facility policy lacked instruction to place a barrier on the floor under the measuring container.	F 880		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed	F 909		11/20/24

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F 909	Continued From page 75 frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct regular inspections of hospital bed rails as part of a regular maintenance program. Findings include: R204's admission Minimum Data Set (MDS) dated 10/4/24, indicated R204 had intact cognition, required partial to moderate assistance with bed mobility, was always incontinent of bowel and bladder, required substantial assistance with dressing, did not have an impairment in range of motion to upper extremities, and did not use bed rails. R204's Medical Diagnosis form undated, indicated the following diagnoses: dementia, urinary tract infection, ulcerative pancolitis (a type of inflammatory bowel disease) with unspecified complications, diarrhea, and Alzheimer's disease. R204's physician orders dated 10/22/24, indicated R204 could have bilateral grab bars. R204's care plan dated 9/28/24, indicated R204 was at risk for falls and interventions included monitoring and documenting on safety, and remove any potential causes if possible. Further, R204 had an alteration in mobility due to Alzheimer's dementia and the goal was R204 would move safely within her environment. An intervention dated 10/22/24, indicated R204 required grab bars to the bed to aid in bed mobility.	F 909	1. R204s left grab bar was repaired and is now securely in place. 2. All beds containing a grab bar were inspected for quality and function. All repairs if needed have been completed. Facility updated TELS work system to conduct bed rail inspections weekly. 3. Maintenance director educated on the expectation for weekly inspections of grab bars to ensure quality and function. All staff educated on reporting grab bar repair needs to Maintenance Director. 4. The maintenance director and/or designee will complete full house audit weekly of grab bars for 4 weeks. Audits will be brought to QAPI by the Director of Nursing and/or designee to determine if audits need to continue. 5. 11/20/2024	

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F 909	Continued From page 76 R204's Bed Mobility Device Evaluation dated 10/21/24, indicated R204 required bilateral grab bars to assist with repositioning in bed. R204's nursing progress notes dated 10/21/24 at 11:54 p.m, 10/22/24 at 1:08 a.m., 10/23/24 at 1:43 p.m., indicated R204 was turned and repositioned frequently. During interview and observation on 10/22/24 at 8:06 a.m., R204's hand rail on R204's left side swung out and was not secured to the bed. R204 stated she used the rail. The hand rail on R204's right side was steady. During observation on 10/23/24 at 7:34 a.m., R204's left sided bed rail was still loose. During interview and observation on 10/23/24 between 10:16 a.m., and 10:36 a.m., nursing assistant (NA)-A and NA-D stated R204 was not able to turn herself in bed. At 10:17 a.m., NA-D stated he was going to assist R204 with cares. At 10:19 a.m., NA-D raised the head of the bed. At 10:20 a.m., R204's hand rails were up on both sides of the bed. At 10:21 a.m., the head of the bed was lowered down. At 10:23 a.m., NA-A and NA-D assisted to turn R204 towards her left side and R204 grabbed the bed rail on the left. At 10:26 a.m., R204 was assisted to turn towards R204's left side and grabbed the bed rail and the rail moved outward. At 10:34 a.m., NA-D raised the foot and head of the bed and at 10:35 a.m. NA-D lowered the bed. At 10:36 a.m. the left hand rail appeared to be missing a part to prevent the rail from moving outward. During interview on 10/23/24 at 1:47 p.m., registered nurse (RN)-A stated the nurse	F 909		

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F 909	Continued From page 77 manager or director of nursing (DON) was notified if bed rails were needed and would contact maintenance to have them installed. RN-A stated everyone checked the rails, and maintenance double checked rails. RN-A stated the nurses checked the rails as often as they could when they went into the room to make sure everything was ok and when in contact with the resident, since things changed on a daily basis. RN-A stated they touched the bed rails, however, may not check all residents' bed rails, and stated it should be completed frequently on a day to day basis. During interview on 10/23/24 at 1:58 p.m., NA-D stated there were no issues with bed rails. During interview on 10/23/24 at 1:58 p.m., licensed practical nurse (LPN)-A stated maintenance checked bed rails for sturdiness and for repairs and if a resident was deemed appropriate for bed rails, therapy and nursing would obtain orders. LPN-A further stated the NAs or residents using the bed rails made sure they were sturdy. LPN-A stated she had not seen whether maintenance completed any recheck on bed rails for sturdiness. During interview on 10/23/24 between 2:24 p.m., and 2:31 p.m., the maintenance director (M) stated a physician's order was needed prior to installing bed rails and further stated bed rails were not placed on the bed until the order was obtained. M further stated he checked to make sure bed rails were in working order and staff notified him if a rail was loose, and stated staff were in residents' rooms working with them and checked to make sure bed rails were in working order. M stated bed rails were checked everyday	F 909		

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F 909	Continued From page 78 adding he walked through the building to check the rooms and looked to see if something looked loose and would shake the rails. M further stated he had not been informed of loose rails. At 2:31 p.m., M verified R204's left bed rail was missing a lock. During interview on 10/24/24 at 10:10 a.m., the administrator stated she expected maintenance to check bed rails on rounds, nursing staff to complete checks, and stated she expected maintenance to get to it on weekly rounds if not daily. A policy was requested as well as a log of when bed rail checks were completed. A maintenance log dated 10/10/24, indicated a bed rail inspection was completed. No other documentation was provided for the bed rail for R204's bed that was ordered on 10/22/24. An email from the administrator dated 10/24/24 at 10:22 a.m., indicated the facility did monthly bed rail inspections, and they were trying to locate a relevant policy, however a policy was not provided.	F 909		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/22/2024. At the time of this survey, The Villas At The Park was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/07/2024

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

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THE VILLAS AT THE PARK	**4415 WEST 36 1/2 STREET** **SAINT LOUIS PARK, MN 55416**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Villas At The Park is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1960 and was determined to be of Type II (111) construction. In 1970, an addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. Because the original building	K 000		

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	245083	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/22/2024**

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K 000	Continued From page 2 and the 2 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (000). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 52 beds and had a census of 48 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 225	1. Door exiting the east stairwell by the dining room has now been scheduled to be repaired to meet the requirement of less than 30 lbf to set door in motion. 2. All exit stairwell doors were inspected and can be set in motion with less than 30 lbf.	11/20/24

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K 225	Continued From page 3 On 10/22/2024 at 11:13 AM, it was revealed by observation that the door exiting out of the east stairwell by the dining room was difficult to open exceeding 30 lbf to set the door in motion. An interview with the Administrator, two Regional Maintenance Directors, and the Maintenance Director verified this deficient finding at the time of discovery.	K 225	3. The maintenance director educated on auditing doors monthly and making repairs as needed. 4. Stairwell exit doors will be audited weekly for 4 weeks to ensure that they can be set in motion with less than 30 lbf. 5. 11/20/2024	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		11/20/24

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the kitchen hood per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.1 and 9.2.3, and NFPA 96 (2011 edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, sections 4.1.3.1 and 11.2.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/22/2024 between 10:00 AM and 12:00 PM, it was revealed by a review of available documentation that on both kitchen hood extinguishing system inspection reports dated 01/11/2024 and 06/06/2024, they stated "additional nozzle needed over range. Change to 1F or 260 coverage" and the facility did not have documentation showing that the repairs had been completed. An interview with the Administrator, two Regional Maintenance Directors, and the Maintenance Director verified this deficient finding at the time of discovery.	K 324	1. Repairs have been scheduled for kitchen hood nozzle to be completed to meet both kitchen hood extinguishing system inspection reports. 2. Inspection reports from the last quarter were reviewed for any other noted repairs that might be needed. No other repairs were found to be needed. 3. Maintenance director educated on the expectation that if a repair is noted as needed it must be completed in a timely manner not to exceed greater than a month. 4. Inspection reports to be reviewed monthly and repairs noted as needed to be brought to monthly safety committee. 5. 11/20/2024	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least	K 363		11/20/24

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K 363	Continued From page 5 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility.	K 363	1. Chair used to hold open room door 202 has been removed. 2. All resident room doors were inspected to ensure that no resident room doors have been propped open inappropriately. 3. All staff educated on not using chairs,	

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K 363	Continued From page 6 Findings include: On 10/22/2024 at 11:21 AM, it was revealed by observation that the door to resident room 202 was being held open with a chair An interview with the Administrator, two Regional Maintenance Directors, and the Maintenance Director verified this deficient finding at the time of discovery.	K 363	trash cans, or other objects to prop open any resident doors. 4. Resident room doors to be audited weekly for 4 weeks to ensure no devices are being used to prop open doors. 5. 11/20/2024	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 10/22/2024 between 10:00 AM and 12:00 PM, it was revealed by a review of available documentation that at the time of the survey the	K 712	1. The maintenance director was provided with a schedule for staggered fire drill times that will be followed for the remainder of the year. This will ensure that times are not repeated in a predictable manner. 2. Fire drill times were reviewed for future dates and are within staggered limits. All shifts have been scheduled. 3. Maintenance Director has been educated on the requirements for	11/20/24

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K 712	Continued From page 7 facility could not provide documentation showing that a fire drill was conducted during the second shift during the fourth quarter of 2023. 2. On 10/22/2024 between 10:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility had not been varying the times that the first shift fire drills were being conducted. The first shift fire drills were conducted on 01/15/2024 at 01:10 PM, 04/12/2024 at 01:10 PM, 07/12/2024 at 11:30 AM, 10/17/2023 at 01:00 PM, and 11/30/2023 at 01:30 PM. An interview with the Administrator, two Regional Maintenance Directors, and the Maintenance Director verified this deficient finding at the time of discovery.	K 712	staggered fire drill times. 4. Fire drill times will be audited monthly via safety committee to ensure compliance with staggered times. 5. 11/20/2024	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2024

Administrator
The Villas At The Park
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083
Cycle Start Date: October 24, 2024

Dear Administrator:

On November 6, 2024, we notified you a remedy was imposed. On November 25, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 20, 2024.

As authorized by CMS the remedy of:

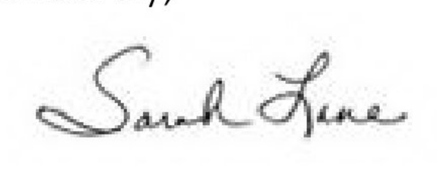
- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 21, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 6, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 21, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 20, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,



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