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

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the physician and guardian were notified of the presence of a skin tear on the buttocks for 1 of 3 residents (R1) reviewed for discharge. Findings include: R1's interim payment assessment Minimum Data Set ((MDS) dated [DATE], noted R1 had moderate cognitive impairment and [DIAGNOSES REDACTED]. R1 did not have any skin tears. R1's progress notes, dated 5/26/20, included, New laceration noted on patient's coccyx during dressing change. The progress notes did not reveal any evidence R1's physician or guardian were notified of the skin laceration. R1's skin integrity events-skin tear/laceration, dated 5/27/20, included R1 had a, Skin tear observed on right buttock near intergluteal cleft (1.5 cm (centimeters) x 1 cm approximately. R1 was noted to be experiencing pain at a 5 on a scale of 0 (no pain) to 10 (excruciating pain), indicating moderate pain. R1 was provided with [MEDICATION NAME] (pain reliever) and topical ointment. Under notifications, there was a No indicated for Attending Faxed, Physician Notified, Resident Representative Notified, and Care Plan Reviewed. R1's discharge orders, dated 5/27/20, included no orders related to a skin tear on right buttock. R1's discharge nurse practitioner progress note, dated 5/27/20, revealed no information related to a skin tear on R1's right buttocks. On 6/12/20, at 3:52 p.m. the registered nurse and unit manager (RN)-B reported she instructed the nurse who discovered the wound on the bottom to notify the physician and guardian of the skin tear. RN-B reported the nurse was not aware the physician and guardian needed to be notified of new skin tears on the bottom. The change in condition policy, undated, directed staff, When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nurse associate consults with the attending provider and notify the resident/resident representative.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the presence of an open area of skin and care instructions for the wound were included in the discharge summary and plan for 1 of 3 residents (R1) reviewed for discharge. Findings include: R1's admission Minimum (MDS) data set [DATE], included moderate cognitive impairment and [DIAGNOSES REDACTED]. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling,) and an unstageable pressure ulcer (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar,) and moisture associated skin damage. R1 required extensive to total assistance with most activities of daily living. R1's progress notes, dated 5/26/20, included,New laceration noted on patient's coccyx during dressing change. R1's progress notes, dated 5/27/20, revealed R1's family guardian (F)-A, picked up R1 for transport to discharge to a group home. The progress notes did not reveal any evidence R1's physician or guardian were notified of the new wound. R1's skin integrity events-skin tear/laceration, dated 5/27/20, noted R1 had a, Skin tear observed on right buttock near intergluteal cleft (1.5 cm (centimeters) x 1 cm approximately. R1 was noted to be experiencing pain at a 5 on a scale of 0 (no pain) to 10 (excruciating pain), indicating moderate pain. R1 was provided with [MEDICATION NAME] (pain reliever) and topical ointment. Under notifications, there was a, No indicated for Attending Faxed, Physician Notified, Resident Representative Notified, and, Care Plan Reviewed. R1's discharge paperwork, including a discharge plan of care, dated 5/27/20, noted no directions related to R1's wound to his buttocks. Under the section for, Wound Care/Treatments there was no information related to wounds or skin issues. R1's discharge orders, dated 5/27/20, noted no orders related to a skin tear on right buttock. R1's discharge nurse practitioner progress note, dated 5/27/20, noted no direction related to a skin tear on R1's right buttocks. R1 was discharged to a group home. On 6/11/20, at 12:43 p.m. a director from the group home was interviewed via phone. The director noted R1 arrived at the group home with a 2.5 inch by 0.5 inch open wound on his buttocks and was in pain. The staff at the group home were not notified by the nursing home of the open area and discovered it a few hours after R1 arrived. The nursing home had not provided any information regarding this wound. On 6/12/20, at 3:52 p.m. the registered nurse and unit manager (RN)-B reported she instructed the nurse who discovered the wound on the bottom to notify the physician for instructions and provide instructions to the group home and guardian. RN-B reported she did not find evidence the physician was consulted for care instructions regarding the skin tear or the group home or guardian provided with written instructions on care for R1's new wound. The discharge planning policy, undated, directed staff, Information provided to the receiving provider must include: d. All special instructions or precautions for ongoing care if appropriate. e. Comprehensive care plan goals. f. All other necessary information including a copy of the discharge summary.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow care planned interventions to heal current pressure ulcers and prevent new pressure ulcers from forming for 1 of 3 residents (R3) reviewed for pressure ulcers. Findings include: R3's admission Minimum (MDS) data set [DATE], included cognitively intact, did not reject cares, required extensive assistance with bed mobility and toileting, [DIAGNOSES REDACTED]. May also present as an intact or open/ ruptured blister.) which was present upon admission. R3's Care Area Assessment Worksheet (CAA) dated 4/23/20, noted that R3 was at risk of developing pressure ulcers, and did have a stage II pressure ulcer on the right buttock from admission. R3 was also noted to have excoriated skin due to frequent incontinent, loose stools. R3 had a decline in function and self care skills with [DIAGNOSES REDACTED]. R3's pressure ulcer care plan last updated 6/12/20, noted pressure areas to sacrum/coccyx and right ear. Interventions included repositioning every two hours and as needed with one or two staff. If resident refuses repositioning/brief check to re-approach within 30 minutes. The care sheet carried by nursing assistants, dated 6/10/20, required staff to reposition R3 every two hours and as needed due to the open area to buttocks and right ear, and to use pillows to offload. On 6/11/20, at 12:18 p.m. R3 was observed in bed, asleep. R3 laid on an air mattress, and the head of the bed was raised approximately 30 degrees. R3 was positioned on her right side. On 6/11/20, at 12:22 p.m. nursing assistant (NA)-A stated knowing how to provide care to the residents because of the care sheet, which was printed weekly, or if there were changes. the care sheet dated 6/10/20, required staff to reposition R3 every two hours, and as needed, with assist of one to two staff. The care sheet also noted R3 had an open area to the buttocks and right ear. On 6/11/20, at 2:11 p.m. NA-A entered R3's room to offer a snack. At 2:13 p.m. R3 was observed in bed and still on her right

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

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 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) side. R3 stated she was comfortable at the moment, with no pain. R3 stated the staff do move her from side to side usually every couple hours or so, and thought they had last repositioned her about an hour and a half ago or so. R3 described having a pressure ulcer on her bottom that had improved, but then said another little one had opened up nearby. R3 also had a, little one on her ear, but stated it did not bother her at all, and staff were putting cream on it. R3 had no concerns with how staff were caring for her skin. At this time, R3 remained on her right side without repositioning since continuous observation started at 12:18 p.m. On 6/11/20, at 2:47 p.m. physical therapist (PT)-C was observed checking in with R3, and stated, I am kind of making the rounds doing strengthening and walking, I take it you're not up for it? R3 responded that she was not up for walking, and PT-C left the room. At 2:48 p.m. PT-C explained having a list of residents to check in with, who had previously been on therapy and discharged with walking programs. PT-C stated he knew R3 was not doing very well, and would not want to walk. On 6/11/20, at 2:55 p.m. NA-A was asked how often R3 got repositioned. NA-A stated R3 will call staff to be moved, but explained staff also repositioned every two hours. NA-A described always repositioning R3 at 7:00 a.m. right when NA-A arrived to work, again at 9:00 a.m., and then again right around 11:00 a.m. when lunch was served, because R3 wanted to lay on her right side to eat. When asked whether 11:00 a.m. was the last time R3 was repositioned, NA-A stated she checked in on R3 about 1:00 p.m. after her break to see if she needed anything, and if she could reposition R3. NA-A said R3 did not want to be repositioned at that time, but maybe later. At this time licensed practical nurse (LPN)-A stated she thought NA-A checked in with R3 after her break, which was closer to 1:30 p.m. NA-A planned to check in with R3 about repositioning again before the end of the day shift. NA-A stated sometimes R3 calls for help with repositioning when she uncomfortable, and stated it was really up to R3 as sometimes she was wanting to move, and other times not. LPN-A confirmed R3 had one pressure ulcer on the coccyx that closed up, and mentioned another new, tiny slit had opened just near the healed area. LPN-A stated R3 was dealing with some difficult recent medical news, and thought that refusing care at times was R3's way of dealing with the news. At 3:01 p.m. NA-A left the unit at the end of the shift, without re-approaching R3 for repositioning as planned. On 6/11/20, at 3:11 p.m. NA-B was working the evening shift, and asked how staff from the day shift passed important information onto the evening shift. NA-B stated she usually talked to a day shift NA if they had time to see what was new, and start taking vitals right away. NA-B was aware that a couple residents, including R3, usually stayed in bed. NA-B said R3 was good at telling staff if she wanted to be repositioned. When asked whether R3 was supposed to be repositioned at certain times, NA-B stated she tried to let R3 call and tell her when she wanted to be repositioned, because NA-B did not want to bother R3. NA-B stated staff tried to keep a pillow behind R3 at least. At 3:22 p.m. when asked what time R3 was last repositioned, NA-B stated she did not know when R3 had last been repositioned. NA-B confirmed that staff did not write that down, and any information about repositioning would be by word of mouth. On 6/11/20, at 3:47 p.m. R3 was observed in bed. When asked if R3 had been repositioned recently, she responded, not yet. R3's legs were still tilted on the right side, but it looked as though she had rolled onto her back a little bit, as her head was more flat on the pillow. On 6/11/20 at 3:58 p.m. LPN-B stated if residents refused repositioning, she would go back in to re-approach and try again in 15 or 30 minutes. LPN-B stated checking in with the resident to encourage repositioning was another ball that staff had to try to keep in the air. LPN-B understood that R3 had gone on hospice recently, and was dealing with a lot, and should have some control over what care she wanted. On 6/11/20, at 4:05 p.m. NA-B exited R3's room, and stated R3 had agreed to be repositioned. NA-B described moving R3 from her right side, to laying on her back on a pillow per resident preference. This was over 4 hours since R3 had been assisted to reposition. On 6/11/20, at 4:11 p.m. registered nurse (RN)-A stated the nurse managers were currently monitoring wounds during weekly wound rounds. RN-A stated when R3 first admitted to the facility, she had a stage II pressure ulcer on her buttocks. A few weeks ago R3 was still walking, and staff were still treating the stage II wound she admitted with. RN-A stated in the past two weeks, R3 had declined according to the unit staff. RN-A stated R3 had been much more incontinent lately, and was not walking like she used to. RN-A was working on a MDS assessment due to the significant change. RN-A explained that the original stage II ulcer on the bottom had closed up earlier that week, but said now today during wound care before lunch, RN-A had seen a new open are that was 1 centimeter (cm) by 1 cm. RN-A described the entire sacral area as purple in color, and said the new open area could be due to shearing or could be due to pressure. RN-A was working on updating the care plan due to the changes, and educated R3 about the importance of repositioning, and telling the staff if R3 thought she was wet. RN-A stated the expectation was for staff to offer repositioning at least every two hours. If R3 refused repositioning, RN-A expected staff to check in within maybe 15 or 30 minutes. RN-A expressed not wanting R3 to feel staff were disrespecting her choices, but wanted staff to re-approach before another two hours had passed. RN-A planned to update the care sheet to guide nursing assistants with when to re-approach if R3 refused repositioning. The Resident Census document in the electronic medical record showed R3 was admitted to the transitional care unit on 4/10/20, and moved to her current long term care (LTC) unit on 5/26/20. A Skin Integrity Event originally dated 4/10/20, noted R3 admitted with a stage II pressure ulcer on the right buttock, and that this area closed on 6/8/20. Skin Integrity Event dated 5/27/20, noted R3 had acquired a stage II pressure ulcer just above the coccyx. Skin Integrity Event dated 6/8/20 noted a stage II pressure ulcer to the right ear that was 0.2 cm by 0.1 cm. A progress note dated 5/27/20, described the open area as 0.3 cm by 0.4 cm with 0.1 cm depth at the time it was discovered. In a progress note dated 5/28/20, the resident reported a history of skin breakdown in this area, with staff noting that R3 had spent almost all her time in bed since moving to her current unit. A progress note from 6/11/20 noted the pressure ulcer from admit on the buttock had resolved, but the new area on the sacrum now measured 1 cm by 1 cm, with depth of less than 0.1 cm. Staff reported resident sometimes declined brief changes or repositioning, and R3 was noted to have significant functional decline and increased incontinence since transfer to the LTC unit. R3 was on hospice with additional decline anticipated. Care sheet and care plan was updated to ensure repositioning every two hours, and re-approaching within 30 minutes if R3 declined. Requested a policy or procedure regarding re-approaching after a resident declined care planned interventions. On 6/12/20, at 12:16 p.m. the director of nursing (DON) sent an email and wrote that they did not have a policy specific to timing of staff re-approach, but said the stance would be to include the resident in the conversation of what was an acceptable plan for them and work on the care plan together, rather than making that decision without resident input. DON mentioned that the care plan was updated to include staff re-approaching after 30 minutes of refusal. The DON clarified it was a fine line of continuously upsetting or bothering residents with re-approach, versus abiding by their wishes and letting them be. The goal was for R3 to be comfortable, and staff planned to check in with R3 in the next week to see how things were going with the plan to re-approach after 30 minutes of refusal. The Prevention and treatment of [REDACTED]. These injuries commonly result from adverse microclimate and shear on the skin over the pelvis. The policy noted staff should evaluate current pressure reduction interventions and revise resident centered care plan, re-evaluating as appropriate, and educate the resident on the pressure injury and care plan interventions.