STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245634	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AURORA ON FRANCE	**6500 FRANCE AVENUE EDINA, MN 55435**

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 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure adequate and required information was documented and communicated to a receiving healthcare facility to ensure continuity of care for 1 of 1 resident (R1) reviewed who had discharged to an assisted living facility. Findings include: R1's admission Minimum Data Set ((MDS) dated [DATE], identified R1 had [DIAGNOSES REDACTED]. In addition, the MDS identified R1 had a stage II unhealed pressure ulcer and received pressure care treatment during the assessment period. During a review of a report submitted to the State Agency (SA) on 6/12/20, it was revealed R1 had been discharged from the facility on 6/11/20, to an assisted living facility. The reporter indicated upon assessing R1's skin on admit on 6/11/20, it was identified R1 had Necrotic pressure sore on the pad of her left heel which measured 7 centimeters (cm) by 9 cm. The report also indicated the facility had failed to report the major skin issue to the assisted living staff during multiple encounters during the discharge process. On the discharge summary sent to the assisted living the facility failed reflect any wound concerns, treatments and interventions in place, to be followed by the receiving facility. On 6/16/20, at 10:25 a.m. registered nurse (RN)-A stated, from her recollection, R1 had a blister on her left heel when she returned to the facility following a hospital stay. RN-A then stated the blister had ruptured and staff nurses were doing wound care/treatments for it using a water base gel dressing twice daily and staff were floating R1's heels. RN-A also confirmed R1 was discharged from the facility accompanied by family members on 6/11/20. On 6/16/20, at 12:35 a.m. the consultant RN reviewed the Discharge Instruction/Recapitulation dated 6/11/20, and verified under skin condition, it was indicated R1 had no skin alterations. -At 12:42 p.m. RN-B clinical coordinator stated when she went to the hospital and came back on 5/27/20, she had the fluid filled blister, and acknowledged that a new wound care order for the blister was not obtained at that time. RN-B then reviewed the wound assessments and nursing notes in R1's medical record and verified from the most recent note dated 6/10/20, another nurse had noted R1 had a stage 2 pressure injury on the left heel and the nurse had indicated the left heel as flat with skin over ulcer, the color was black surrounded by pink and reddened skin. Also the nurse had described the outermost layer of pressure injury was less macerated, white in color; the pressure injury was bigger measuring 4.0 centimeters (cm) length by 3.5 cm Width and the distal part of pressure injury continued to peel off. On 6/16/20, at 1:02 p.m. the licensed social worker (LSW) stated during the care conference held on 6/3/20, R1's progress was discussed which included medical and therapy. The LSW then stated after the care conference she was in touch with the assisted living staff in the days leading to discharge and confirmed the discharge however, she did not discuss anything regarding R1's skin. On 6/16/20, at 1:10 p.m. the director of nursing (DON) via telephone stated she was aware R1 had a pressure ulcer on the left heel. When asked about the facility discharge process, she stated we have a whole checklist which goes with the residents and the nurse practitioner (NP) will also complete a discharge summary that goes with them. The nurse practitioner knows the skin concerns the resident has as they know this residents well and they send all that. The DON asked the consultant RN to find the NP discharge summary. -At 1:32 p.m. the consultant RN reviewed R1's Geriatric Services Discharge Summary dated 6/9/20, and verified left heel alterations, treatments and discharge care instruction/interventions were not addressed. The facility Discharge Plan and Recapitulation 3.3-V2 policy revised 5/19, indicated on the discharge summary, skin conditions section was supposed to be completed by the nurse manager or nurse and the nurse manager was supposed to ensure it was completed timely and accurately.

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