

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Maplewood Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Sherren Avenue East Maplewood, MN 55109	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49338</p> <p>Based on observation, interview, and document review, the facility failed to monitor edema and comprehensively assess non-pressure related wounds for 1 of 1 resident (R2) reviewed.</p> <p>Findings Include:</p> <p>R2's admission Minimum Data Set (MDS) dated [DATE], indicated R2 was admitted on [DATE] with diagnoses including malignant neoplasm of brain (brain cancer), hypertension, and chronic ischemic heart disease (weakening of the heart caused by reduced blood flow) and was receiving hospice care.</p> <p>R2's active physician order dated 2/19/24, directed nurses to chart R2's condition in nurse's notes every shift for edema (fluid retention in body tissues that can result in swelling and/or weight gain) checks noting edema as present or not present and lung checks noting lungs as clear or not clear.</p> <p>R2's treatment administration records (TAR) were reviewed in conjunction with progress notes and skin evaluations, it was not evident edema was consistently comprehensively evaluated. Although the TAR's which identified the physician orders for edema checks and lung sounds were completed, the extent of edema was not included. Instead the TAR for edema monitoring documentation had plus signs (+) indicating edema was present or minus signs (-) indicating no edema. In the boxes for lung sounds the boxes identified (c) for clear and (+) for not clear.</p> <p>R2's active physician order dated 2/19/24, directed staff to complete weekly weights for R2 every Thursday.</p> <p>R2's weight record was reviewed in conjunction with progress notes and skin evaluations, R2's weight record identified between 2/19/24 to 4/25/24, R2 had a weight gain of 16.2 pounds (lbs). It was not evident R2's weight gains were comprehensively assessed to ascertain if the gains were nutritional and/or fluid related in order to evaluate for a change in R2's overall health status and possible disease progression and further treatment needs.</p> <p>Weights documented in R2's electronic health record (EHR) included:</p> <p>181.4 pounds (lbs.) on 4/25/24 at 2:34 p.m.</p> <p>181.4 lbs. on 4/25/24 at 12:48 p.m.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	177.2 lbs. on 4/18/24 at 1:58 p.m. 177.2 lbs. on 4/18/24 at 1:55 p.m. 177.2 lbs. on 4/18/24 at 1:52 p.m. 180.8 lbs. on 4/11/24 at 2:47 p.m. 180.8 lbs. on 4/11/24 at 1:59 p.m. 181.0 lbs. on 4/4/24 at 2:56 p.m. 181.0 lbs. on 4/4/24 at 12:28 p.m. 182.4 lbs. on 3/28/24 at 12:18 p.m. 182.4 lbs. on 3/28/24 at 10:13 p.m. 177.4 lbs. on 3/21/24 at 1:44 p.m. 177.4 lbs. on 3/21/24 at 12:40 p.m. 176.6 lbs. on 3/14/24 at 8:59 p.m. 176.6 lbs. on 3/14/24 at 2:00 p.m. 176.6 lbs. 3/14/24 at 9:33 a.m. 175.4 lbs. on 3/7/24 at 1:59 p.m. 175.4 lbs. on 3/7/24 at 1:36 p.m. 171.4 lbs. on 2/29/24 at 2:49 p.m. 171.4 lbs. on 2/29/24 at 1:30 p.m. 169.6 lbs. on 2/22/24 at 10:42 a.m. 169.6 lbs. on 2/22/24 at 10:21 a.m. 165.2 lbs. on 2/19/24 at 2:20 p.m. 165.2 lbs. on 2/19/24 at 12:49 p.m. 165.2 lbs. on 2/19/24 at 12:32 p.m. (continued on next page)

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A provider note dated 2/21/24, from R2's initial encounter indicated due to progressive functional and cognitive decline, oncology recommended transition to hospice. He is admitted here for LTC [long term care] on [agency name] hospice. It also noted R2 reported he quite smoking [AGE] years ago and his smoking use included cigarettes.</p> <p>R2's Weekly Skin Inspection dated 2/22/24, noted R2 had large bruises on his left inner and outer elbow and a scar, bruising on bilateral lower extremities (BLE, both legs), a scar on the left shin, and scratches on knees and shin. It did not note any other skin concerns or edema.</p> <p>R2's Skin Evaluation and Skin Risk Factors assessment dated [DATE], noted R2 had a left antecubital (inner elbow) skin tear, bruising on the left elbow, scar on the left elbow, and identified a skin issue on the left forearm but did not specify what type of issue. The description and summary sections noted R2 had a large superficial skin tear on his left forearm and an unspecified wound bed looked red. Drainage was listed as N/A, the periwound description and measurements were not completed. Risk factors selected from a pre-populated list of options were psychotropic drug use. R2's hypertension, cancer, history of smoking, left side hemiparesis, and cognitive impairment were not identified. The summary indicated R2 had no feeling on the left side as he said his left side upper and lower extremities are numb. No interventions were listed in the interventions section.</p> <p>R2's Wound Evaluation Form dated 2/23/24, noted a left forearm skin tear that was superficial with a red wound bed. A dressing was applied to the wound bed and covered with a gauze, no pain was associated with wound care. The measurements section was not completed. No additional Wound Evaluation Forms were identified during review of R2's EHR.</p> <p>A hospice communication note date 2/26/24, indicated wound care was completed for the left arm and included the following measurements of unspecified wounds: 4 x 2.5 centimeters (cm), 2.5 x 2 cm, 1 x 1 cm, 1 x 0.5 cm, and 1 x 0.5 cm. Information about the specific wound locations, types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's Weekly Skin Inspection dated 2/29/24, bruising on the left elbow, arm, and back of left hand, some scars and skin tears, bruising and scars on the back of the right hand, bruising on BLE, and signs of edema on both feet. Information about the specific wound locations, wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. Assessment of the edema was also not documented.</p> <p>A hospice communication note dated 3/1/24, indicated wound cares were completed on the left arm and included measurements of 4.5 x 1.5 cm outer left forearm wound, 2 x 1.5 cm inner left forearm wound, 1 x 1 cm elbow wound, and 1 x 1 and 0.5 x 0.5 cm wounds on the bottom of the left arm. Information about the wound types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>A hospice communication note dated 3/5/24, indicated wound care was performed and included wound measurements of 3 x 2 cm, 0.5 x 1 cm, and 1 x 1 cm on the left top arm and 2 x 2 cm, 0.5 x 0.5 cm, and 1 x 1 cm on the left bottom arm. Information about the specific wound locations, wound types, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's active physician order dated 3/7/24, directed staff to apply Velcro wraps (compression wraps) to BLE.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Weekly Skin Inspection dated 3/7/24, noted R3 had bruising on BLU (possible mis-type of BUE, bilateral upper extremities) and BLE with scars. It did not identify any edema or further skin issues.</p> <p>A hospice communication note dated 3/8/24, indicated wound care was performed. No information about the wounds was documented.</p> <p>A hospice communication note dated 3/11/24, indicated wound cares were completed on the left arm, four of five wounds were resolved, and included a measurement of 0.8 x 1 cm of a wound on [illegible] left forearm. Information about the wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>A progress note dated 3/12/24, noted a 30-day nutritional review was completed by dietary and identified a weight of 175.4 lbs. on 3/7/24, weight gain noted since admission, family and hospice updated, registered dietician will continue to observe per facility protocol.</p> <p>A progress note dated 3/12/24, noted R2 said he was going through a door and squeezed his left arm against the door, sustaining a skin tear on the left elbow. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's care plan identified a risk for alteration in skin integrity related to frail skin, left-sided hemiparesis (one-sided muscle weakness), and weakness dated 3/13/24. Interventions included application of a geri-sleeve (sleeve to protect fragile skin) to left and right arms covering R2's hands, forearms, and elbows to prevent skin tears/abrasions, inspection of skin daily with nursing aides to report any concerns to nurse, and weekly skin assessment by licensed staff. R2's skin care plan did not identify his edema or included related interventions.</p> <p>R2's Skin Evaluation and Skin Risk Factors assessment dated [DATE], identified a left elbow skin tear. The wound bed was described as approximated edges with steri-strips (adhesive bandages) applied. It noted the periwound area (skin surrounding the wound) was intact and the wound bled a small amount at first with no further drainage. The presence of a new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were cognitive impairment and other: left side hemiparesis. R2's psychotropic drug use, hypertension, cancer, and history of smoking were not identified. Interventions included R2 wearing a geri-sleeve on the left arm. The summary described the incident causing the skin tear.</p> <p>R2's Weekly Skin Inspection dated 3/14/24, noted bruising on bilateral upper extremities (BUE) with wounds in healing on the left arm and scars as well as bruising on BLE. Information about the number and location of the wounds on the left arm, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema.</p> <p>A progress note dated 3/15/24, noted a new small skin tear with a scab forming on the left forearm was identified while resident's geri-sleeve was removed for a shower. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A hospice communication note dated 3/15/24, indicated wound care was completed for the left arm. Information about the number and location of the wound(s) on the left arm, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's Skin Evaluation and Skin Risk Factors assessment dated [DATE], noted skin tears on the left elbow and left forearm. The wound bed noted steri-strips on the left elbow skin tear and a small skin tear on the left forearm with a scab forming and Band-Aid applied. Drainage description noted scant blood but did not identify the associated wound(s). The periwound area was described as intact with no open areas. The presence of a new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were cognitive impairment, psychotropic drug use, and other: left side hemiparesis. R2's hypertension, cancer, and history of smoking were not identified. Interventions included geri-sleeve on left arm, wheelchair cushion, and an extended wheelchair arm rest for the left side requested from hospice. Information about the wound measurements and pain was not documented.</p> <p>A hospice communication note dated 3/19/24, indicated wound care was completed for the left leg and left arm. It noted left leg is new, unsure cause but appears vascular due to edema. Information about the extent of the edema was not identified. Further the number and location of the wounds, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's Weekly Skin Inspection dated 3/21/24, noted bruising on BUE with scars on the back of both hands and open wounds on the left elbow, bruising on BLE, scars and a wound on the left shin, and bruising on the left side of the neck. Information about the number and location of the wound(s) on the left elbow, the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema.</p> <p>A hospice communication note dated 3/21/24, indicated wound care was completed, there was no complaint of pain, no signs or symptoms of infection, and included the following measurements: 1.5 x 1 cm left lateral arm wound, 3 x 2 cm left arm wound, and 1 x 0.5 cm left leg wound. Information about the wound beds, drainage, odor, periwound area and wound edges, and risk factors was not documented.</p> <p>A progress note dated 3/22/24, noted assessment was done of the right leg due to the weekly skin check indicating the presence of a wound. No wound or open area was noted, a small intact scab was identified.</p> <p>A hospice communication note dated 3/25/24, indicated wound care was completed on the left leg and arm. It noted several new wound[s] to left arm, will reassess on next visit for measurements. Information about the specific location of the wounds, measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's active physician order dated 3/25/24, directed that R2 take 4 milligrams (mg) of dexamethasone (a steroid medication) by mouth once daily.</p> <p>R2's Weekly Skin Inspection dated 3/28/24, noted bruising on BUE with scars, an open area on the left forearm, bruising on the right lower extremity, and small scab on the right lower shin. Information about the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. It did not identify edema.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Fall from Chair report dated 3/28/24, noted R2 fell and sustained injuries including bleeding from the left elbow at the site of a previous injury, and a skin tear in the inner upper arm. The left elbow injury was identified as a skin tear. Information about the measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>A progress note dated 3/31/24, noted R2 was found on the floor and sustained skin tears on the right arm and left hand. Information about the specific of the right arm wound, wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>A progress note dated 3/31/24, noted the on-call provider ordered monitoring of R2's skin tears.</p> <p>R2's Weekly Skin Inspection dated 4/4/24, noted bruising and scars on BUE, right lower extremity bruising, and a scab on the right shin. It did not identify edema.</p> <p>R2's Weekly Skin Inspection dated 4/11/24, noted bruising and scars on BUE, multiple bruises on the left arm, bruising on the right lower extremity, and a superficial scratch on the right thigh. It did not identify edema.</p> <p>A progress note dated 4/12/24, noted R2 bumped his hand on the toilet grab bar when sitting down and sustained a skin tear on the right hand. Information about the wound measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>R2's Skin Evaluation and Skin Risk Factors assessment dated [DATE], noted a skin tear on the back of the right hand. The description noted it was superficial with a wound bed of 100% epithelial tissue, drainage was a small amount of bleeding, and the periwound area had peeled skin around the edges of the wound. A new wound prompting assessment was marked yes. Risk factors identified included other: hemiplegia and frail skin. R's psychotropic drug use, steroid medication, hypertension, cancer, history of smoking, and cognitive impairment were not identified. No interventions were identified.</p> <p>R2's Weekly Skin Inspection dated 4/18/24, noted bruising and scars on BUE, a scar on the right thigh, and some small bruising on the right lower extremity. It did not identify edema and noted there were no other skin issues at the time.</p> <p>A Fall Review Evaluation dated 4/20/24, noted R2 fell in the bathroom and no injury was found.</p> <p>A progress note dated 4/22/24, noted the inter-disciplinary team reviewed R2's fall on 4/20/24 and R2 had a small, scabbed area on his right posterior arm related to the fall. It did not include further assessment of the newly identified scabbed area.</p> <p>A progress noted dated 4/22/24, noted R2 had a skin tear on his right arm close to the elbow and the nurse manager was notified. Information about the wound measurements, wound bed, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented.</p> <p>A progress note dated 4/24/24, noted R2 obtained a skin tear on 4/24/24 and had fragile skin and was at high risk for skin tears. Information about the specific wound location, wound measurements, wound bed, drainage, odor, periwound area and wound edges, specific risk factors, and pain was not documented.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's Skin Evaluation and Skin Risk Factors assessment dated [DATE], listed left elbow skin tear injury. The wound beds were described as superficial with a red periwound area. The summary noted R2 had two open area on his left elbow that looked superficial. The drainage section was not complete. A new wound prompting assessment was marked yes. Risk factors selected from a pre-populated list of options were psychotropic drug use. R2's steroid medication, cognitive impairment, hemiparesis, hypertension, cancer, and history of smoking were not identified. No interventions were identified. Information about wound drainage, odor, pain, and measurements was not documented.</p> <p>R2's Weekly Skin Inspection dated 4/25/24, noted wounds on the left elbow and bruising, bruising and a wound on the right forearm, and bruising on the left lower extremity. Information about the specific number and location of the left elbow wounds, measurements, wound beds, drainage, odor, periwound area and wound edges, risk factors, and pain was not documented. No edema was identified.</p> <p>A hospice communication note dated 4/25/24, indicated wound care was completed on the Lt. FA [left forearm?], there was stinging afterwards, and R2 took a dose of as needed Tylenol. Information about the number of wounds, wound measurements, wound beds, drainage, odor, periwound area and wound edges, and risk factors was not documented.</p> <p>R2's Treatment Administration Record (TAR) included the active physician order for edema checks. Charting from the day shift on 4/29/24 noted no edema was present.</p> <p>During an observation on 4/29/24 at 10:22 a.m., R2's feet were examined with registered nurse (RN)-A. RN-A stated R2's right foot was swollen with pitting edema measuring 2+ to 3+ (edema that leaves a dimple after being pressed is pitting and is measured by depth of indentation from 1+ most shallow to 4+ deepest) that extended up to his ankle. RN-A stated R2's left foot had pitting edema of 1+ on the inner side and 2+ on the left side extending up to his ankle. RN-A stated R2 had a history of edema and staff put socks and Velcro wraps on him every day and checked his feet and edema at this time. RN-A indicated that she would complete a progress note if edema was noted or, on shower days, a skin check was completed and she would include the edema in that documentation. RN-A stated if a nurse saw edema they would document it and include if it was trace edema, pitting edema, and the grade.</p> <p>During an interview on 4/29/24 at 10:26 a.m., R2 stated he wore the Velcro sleeves on his legs to help with the swelling and before he wore them his skin was swelling up so much it was breaking open. R2 stated the swelling was present for at least the last six months in both of his feet and he wore the Velcro sleeves every day.</p> <p>In an interview on 4/29/24 at 11:08 a.m., the director of nursing (DON) stated edema is monitored through daily observation from the aides who would notify the nurse of any concerns. The DON stated nurses also observe residents when they give medications and complete weekly skin checks. The DON noted the weekly skin checks should say if edema was noted and if it was pitting and the grade. The DON stated that if it was not the day of the week for the weekly skin check then edema would be documented in a progress note. The DON stated R2 had Velcro wraps applied daily, on in the mornings and off at bedtime. The DON confirmed that R2's TAR indicated no edema was present the prior day or that morning and stated she guessed it was not being specifically monitored other than when the Velcro wraps were applied. The DON noted staff were not monitoring R2's edema every shift or at least were not doing good documentation of doing so and R2's physician order directed staff to monitor the edema every shift. The DON stated she would expect edema to be on a resident's care plan, it should be captured in the skin section, and R2 had a skin care plan but it did not include edema.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In the same interview on 4/29/24 at 11:08 a.m., the DON noted the facility had a dietician who monitored and audited resident weights weekly. The DON stated a significant weight change would probably be about a five lb. increase in one week. The DON identified that dietary updated hospice about R2's weight gain on 3/12/24 regarding his weight of 175.4 lbs. on 3/7/24. The DON confirmed that R2's weight on 4/25/24 was 181.4 lbs., which was an increase of 16 pounds since admission and 6 lbs. since 3/7/24. The DON stated she would expect hospice to be notified of the continued weight gain and there was no charting indicating hospice had been updated since 3/12/24.</p> <p>In the same interview on 4/29/24 at 11:08 a.m., the DON stated comprehensive assessments of wounds included the skin evaluation and would identify the site of the wound, if there was drainage, the type of wound, if someone had medications or diagnoses with the potential to delay healing or increase risk of compromised skin integrity, and what follow-up or treatments were. The DON stated she would want a description of the wound and what it is and the size of the wound and the facility always captured the size of a wound for the purpose of tracking healing. The DON confirmed that documentation of skin tears in R2's EHR included descriptions such as them being superficial and some included a description of small or large but they did not include length or width measurements and specifics of the exact sizes of the wounds were missing.</p> <p>Facility policy titled Resident Weight Evaluation dated 9/2012, included: Policy Statement: . To ensure that resident weight gains and losses are assessed regularly based on a comprehensive resident assessment and that follow-up interventions are implemented to ensure the resident reaches their highest potential . Policy Interpretation and Implementation: . 3.) When a weight is completed, it is documented on the Electronic Record by the nurse. The record will have a history of at least two months of past weights on it. Should the nurse note a five pound weight</p> <p>increase or decrease, he/she must weigh that individual again; 4.) If there is a weight change that meets the above criteria, the charge nurse and Hospitality Services Director determine the appropriate intervention and make a referral to the Dietitian. The Dietitian initiates a preliminary assessment to determine the cause and charts this in the nurses' notes. (Appropriate interventions might be requesting a diet change, encouraging low or high calorie snacks, [NAME] Plus, milkshakes, lab work, weekly weights, double desserts, etc.); 5.) At the discretion of the charge nurse and dietician, the Physician is notified.</p> <p>Facility policy titled Skin Assessment & Wound Management dated 3/2024, included: When a significant alteration in skin integrity is noted (i.e. large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken . 10.) Initiate Skin and Wound Evaluation; 11.) Notify Nurse Manager/Wound Nurse; 12.) Referral to dietary, if appropriate; 13.) Referral to therapies, if appropriate; 14.) Review and update care plan including interventions; 15.) Update resident care lists; 16.) Updated care plan to identify risks for skin breakdown.</p> <p>A facility policy regarding management of edema was requested but not provided.</p>		