STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnesota Masonic Home Care Center	11501 Masonic Home Drive Bloomington, MN 55437

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure care-planned interventions to promote appropriate fluid balance were consistently implemented and accurately tracked to promote continuity of care for 1 of 1 resident (R15) reviewed who received hemodialysis and was on a fluid restriction. Findings include: A National Kidney Foundation (NKF) Fluid Overload in a Dialysis Patient feature, dated 2024, identified fluid overload in a dialysis patient occurs when too much water builds up within the body. The feature added, It can cause swelling, high blood pressure, breathing problems, and heart issues. The feature explained, When you are on dialysis, your kidneys are no longer able to keep the right balance of fluid in your body . That's why it's so important to limit how much sodium (salt) and fluid you have between dialysis treatments, adding further, Follow the fluid guidelines [bolded] given to you . Most dialysis patients need to limit their fluid intake to 32 ounces per day. R15's admission Minimum Data Set (MDS), dated [DATE], identified R15 had moderate cognitive impairment and had multiple medical conditions including anemia, atrial fibrillation or cardiac dysthymia, heart failure, and end-stage renal disease. Further, the MDS recorded R15 received dialysis treatments while a resident at the center. R15's dialysis care plan, initiated 11/14/24, identified R15 had chronic kidney disease and a history of acute kidney injury (AKI) and received dialysis treatments. The care plan listed multiple goals for R15 including, Resident's fluid balance will be maintained and complications minimized as evidenced by non-labored breathing and maintenance of target weight ., along with several interventions to help R15 meet these goal(s) including, Dialysis: Document intake and output (1500ml [milliliters] fluid restriction). (continued on next page)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/24 at 2:54 p.m., R15 was observed in her room lying in bed with family member (FM)-E present at the bedside. R15 stated she was on dialysis, which FM-E verified, and on a Tuesday - Thursday - Saturday schedule. On the wall of R15's room, a white-colored cup picture was present which had, 1500, written on it. However, present on R15's bedside table were multiple white Styrofoam cups and a single hard plastic pitcher with water in it. The cups were inspected and each had remaining fluid inside of them. FM-E stated R15 was on a fluid restriction, however, when questioned on if R15 was maintaining that restriction FM-E laughed and pointed at the multiple cups with fluid adding aloud, I don't know. R15 stated she was unsure how much fluid was given to her at meals or medication pass, nor how it was being tracked if at all adding aloud, I really don't know. FM-E and R15 verified the center' staff provided each of the cups, and R15 denied needing any extra dialysis runs due to fluid overload. When interviewed on 12/17/24 at 1:26 p.m., nursing assistant (NA)-A stated R15 was on dialysis and had been doing pretty well with eating but seemed to never drink much adding it was more just sips [fluids]. NA-A stated they had been trying to offer R15 more fluids, including flavored waters, lately as a result adding, I want to give her options. NA-A verified R15 was on a current fluid restriction, and stated the aides were tracking the consumed fluid within the point of care (POC) system on their charting. NA-A stated fluid intake should be charted every shift to capture fluids at bedside and with meals, and expressed there was no reason fluid for each shift wouldn't be entered into the POC adding aloud, You always should record. NA-A reiterated the aides were responsible to monitor and track fluid intakes for R15 adding aloud, I think it's more on us. Further, NA-A stated they were unsure who added it and monitored the totals of fluid to ensure R15 didn't breach her fluid restriction adding aloud, I really don't know the nursing part of it. R15's POC Response History, printed 12/17/24, identified data collected for the previous 17 days and listed the charting as, Amount of fluids in cc's. The charting then provided the respective dates, times and amounts recorded by the staff for each day. However, multiple days lacked evidence of three collected totals (i.e., every shift). This included but was not limited to: On 12/1/24 (Sunday), only two collected values were listed at 1:06 a.m. and 2:21 p.m. The total fluid intake for the entire day was 360 cubic centimeters (cc). On 12/2/24 (Monday), only one collected value was listed at 5:51 a.m. The total fluid intake for the entire day was 60 cc. On 12/6/24 (Friday), only two collected values were listed at 6:49 a.m. and 10:35 p.m. The total fluid intake for the entire day was 360 cc. On 12/8/24 (Sunday), only one collected value was listed at 3:45 a.m. The total fluid intake for the entire day was 60 cc. The POC charting lacked any further dictation or evidence on R15's fluid intakes for the shifts not listed, including fluids provided with meals, happened on those respective shifts. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 12/17/24 at 1:38 p.m., licensed practical nurse (LPN)-C verified they were the current nurse assigned to R15's room for care, however, expressed it was not their typical floor to work on adding they had never worked with her [R15]. LPN-C stated they had, however, worked with other patients on dialysis and explained residents' on a fluid restriction used the smaller Styrofoam cups and staff don't bring in the big cup [pitcher]. LPN-C the smaller cups were used to better track how much fluid was being consumed and verified the aides were supposed to chart the fluid intakes under the POC. LPN-C stated the nurse then tracked the fluids in the Treatment Administration Record (TAR) which was more a running total of the data collected by the aides but combined with fluids the nurse provided to the patient, too, so the data in the TAR was the cumulative intake for both. LPN-C stated both the TAR data and POC data should be done every shift adding aloud, It's a lot of communication [between nurse and NA]. R15's TAR, dated 12/2024, identified a nursing order which read, 1500ml fluid restriction. Document Intake . every shift Total previous 24hrs on PM shift [current shift + previous AM and NOC [night]], with an order date recorded, 11/18/2024. The TAR listed three shifts along with spacing to record cc (ml) consumed and staff initials. However, the recorded data had multiple days with either blank spaces left, non-discernable amounts, or inaccurately added data. This included but was not limited to: On 12/2/24, a total fluid intake was recorded as 820 cc. The three shifts used to determine this value were recorded as 60 cc, 400 cc, and 360 cc (total 820 cc). However, the POC charting for the same period had additional fluid amounts recorded which were not included in the total recorded on the TAR. On 12/6/24, a total fluid intake was recorded as 640 cc. The three shifts used to determine this value were recorded as 60 cc, 300 cc, and 220 cc (total 580 cc). However, the POC charting for the same period had additional fluid amounts recorded which were not included in the total recorded on the TAR. On 12/13/24, the shift labeled, 11-7, was left blank and not completed. On 12/18/24, at 9:01 a.m., registered nurse unit manager (RN)-A was interviewed, and verified they had reviewed R15's medical record and fluid intakes. RN-A explained the NA was responsible to track the fluid intakes at meals and report the information to the nurse who tracked the fluid provided while giving medications or with ice chips. RN-A verified the TAR data should be the cumulative intake collected from the NA and nurse together which should be added to provide the total amount consumed for a 24 hour period as directed by the TAR directions. RN-A reviewed the POC charting and acknowledged multiple gaps of missing data adding staff should be charting it. RN-A reviewed R15's TAR and acknowledged the 'total' amount recorded on multiple days did not add up correctly given all the recorded data points which likely lead to inaccurate amounts recorded. RN-A stated it was important to ensure R15's fluid intake was tracked accurately and consistently so she's not going over her fluid restriction, adding further R15 was currently hospitalized for another reason but was found also to be a little dehydrated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility Care Plans policy, dated 5/2023, identified the care center provided resident-centered care in accordance with the resident's preferences and stated goals as outlined within the care plan. The policy outlined the comprehensive care plan was developed by the interdisciplinary team (IDT) and would outline interventions to help each resident meet their respective highest physical, social and mental well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614 Based on observation, interview and document review, the facility failed to follow physician orders, or notify the provider of resident's refusal for 1 of 1 residents (R88) reviewed for cervical collar use. In addition, the facility failed to implement and reassess an individualized bowel management (BM) protocol for 1 of 1 resident (R60) reviewed for constipation. Findings include: R88's face sheet, printed on 12/17/24, included diagnoses of posterior displaced type II dens fracture (involving the area of the dens between the inferior aspect of the anterior C1 vertebrae {upper neck} which occurs due to forces such as trauma and can be life threatening due to its proximity to the spinal cord and brainstem) , Alzheimer's disease, and dementia. R88's significant change Minimum Data Set, dated dated [DATE], indicated R88 had severe cognitive impairment with delirium including inattention that fluctuates, but no behaviors including rejection of care. In addition it documented R88 required substantial to maximal assistance for transfers, bed mobility, and eating. R88 had one fall with major injury and is receiving pain medications for pain management and R88 was enrolled in hospice. R88's plan of care dated 12/17/24, included medical problems with a history of falls. Care plan interventions included cervical collar on at all time and if R88 removes collar, report to nurse immediately as the nurse needs to place it back on. A separate intervention dated 11/26/24 included to leave cervical collar in place. A hospital Discharge Summary, dated 11/7/24, included discharge diagnoses of traumatic closed fracture of C1 vertebra with minimal displacement with cause of injury accidental fall. A provider order, dated 12/7/24, included cervical collar to be in place at all times. If R88 removes it, nurse to replace collar every shift for cervical fracture. During observation and interview on 12/17/24 at 10:44 a.m., R88 was lying in bed, head of bed at 30 degrees with her cervical neck collar off and located at the top of the mattress to R88's left side. Registered nurse (RN)-B was present in the room giving R88 her pain medication. R88 stated she was having pain in her neck. RN-B stated R88 is supposed to have her cervical collar on at all times but frequently takes it off. RN-B did not request R88 to put on the cervical collar. RN-B indicated she is not sure if R88's hospice team or the provider is aware R88 is removing her cervical collar or refusing to wear it at times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview on 12/17/24 at 1:00 p.m., R88 was laying across her bed side ways with no cervical collar on with her neck unsupported by the mattress and feet on the other side of the mattress not touching the floor. At 1:02 p.m., nursing assistant (NA)-E entered the room and helped R88 sit on the edge of the bed. R88's cervical collar remained on the top of the mattress. Using an EZ stand (mechanical lift), NA-E got R88 standing and assisted with toileting prior to placing in a Broda chair (specialty chair with head support) at 1:26 p.m. NA-E put on cervical collar and stated R88 removes her collar and doesn't like it on until she is up in her chair. NA-E added R88 frequently refused to wear the cervical collar and the nurses were aware of this. On interview 12/17/24 at 2:46 p.m., licensed practical nurse (LPN)-D, also identified as nurse manager, indicated R88 should have her cervical collar on at all times per provider order and it is not okay to get her up without it on. LPN-D stated if she is refusing, the physician or hospice should be notified. LPN-D confirmed there is no documentation in her electronic medical record at present indicating she has been refusing to wear the cervical collar or that the hospice agency or provider have been notified. On observation and interview 12/18/24 at 7:34 a.m., R88 was lying in bed with cervical collar out of reach on her bedside table. LPN-E entered the room and stated R88 is supposed to have her cervical collar on at all times but frequently refuses to wear it. LPN-E indicated sometimes R88 cooperates with wearing it and other times she refuses. On interview 12/18/24 at 8:52 a.m., registered nurse (RN)-C, hospice nurse, indicated he wasn't aware R88 was refusing to wear her cervical collar. RN-C indicated if the orders states she should wear it at all times, then the facility should ensure she is wearing it or let hospice or the provider know of the refusal. On interview 12/18/24 at 10:37 a.m., the director of nursing (DON) indicated if the provider order states she is to wear the cervical collar at all times, she should be wearing it. The DON added if she takes it off, staff should notify hospice and see if she if she really needs it or not. A policy on devices, and physician orders was requested and none received. 48065 R60's annual Minimum Data Set (MDS) dated [DATE], indicated R60 was cognitively intact, had no behaviors, was frequently incontinent of bowel, and didn't have a toileting program. The MDS also indicated, R60 was dependent with toileting, needed maximal assistance with dressing, transfers, bed mobility, showers, set up for eating, and oral hygiene. R60's MDS indicated diagnoses of coronary artery disease (damage or disease in the heart's major blood vessels), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), hypertension (high blood pressure), hyperlipidemia (high levels of fat particles in the blood), and hemiplegia (paralysis of one side of the body). R60's Diagnosis report dated 12/19/24, indicated diagnoses of slow transit constipation (a condition where the large intestine moves waste too slowly, causing chronic constipation and sometimes uncontrollable soiling), cervicalgia (neck pain), inflammatory poly-arthropathy (a condition in which multiple joints are inflamed) , and left side hemiparesis (weakness or the inability to move one side of the body) and hemiplegia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R60's medication administration record (MAR) printed on 12/18/24, included the following orders: * Senna-docusate sodium (laxative used for constipation) tablet 8.6-50 milligrams (mg)- give 2 tablets by mouth twice a day, hold for loose stools, order dated 4/10/24. * Miralax packet (laxative used for constipation) give 17 grams (gm) by mouth in the morning for constipation, hold for loose stools, order dated 5/11/22. * Miralax packet 17 gm by mouth as needed (PRN) for constipation daily, order dated 5/11/22. * Offer prune juice every morning, order dated 5/10/22. R60's Bowel/Incontinence care plan printed on 12/19/24, indicated R60 was incontinent with some control, and was dependent on staff for assistance. R60's care plan interventions directed staff to, * Implement Standing House Order for constipation if no BM in 9 shifts. * Dieticians consult as needed. * Provide loose fitting, easy to remove clothing. * Provide pericare after each incontinent episode. R60's Bowel Elimination Task form printed on 12/18/24, contained information completed by the nursing assistants caring for R60 every shift, for a total of 3 shifts a day or morning (AM), evening (PM), and night (NOC) and included documentation as follows: * 11/19/24- BM, AM & PM shifts. * 11/20/24 - no BM * 11/21/24- BM, AM shift * 11/22/24 - no BM * 11/23/24 - no BM * 11/24/24 - BM, AM shift * 11/25/24 - no BM * 11/26/24 - BM, AM shift * 11/27/24 - no BM * 11/28/24 - BM, AM shift * 11/29/24 - BM, AM shift (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* 11/30/24 - BM, AM & PM shifts. * 12/1/24 - no BM * 12/2/24 - no BM * 12/3/24 - no BM * 12/4/24 - BM, AM shift * 12/5/24 - BM, AM shift * 12/6/24 - no BM * 12/7/24 - BM, PM shift * 12/8/24 - BM, AM shift * 12/9/24 - BM, AM shift * 12/10/24- BM, AM shift * 12/11/24 - no BM * 12/12/24 - BM, AM shift * 12/13/24 - No BM * 12/14/24 - No BM * 12/15/24 - no BM * 12/16/24 - BM, PM shift * 12/17/24 - BM, AM shift During interview on 12/16/24 at 6:11 p.m., R60 was in his room and sitting in a wheelchair (WC). R60 stated I would like to visit with you, but I am extremely constipated. I have severe abdominal pain. It must be at least 4 to 5 days since I had the last BM. Please, please call the nurse and let her know I am in pain, I am constipated. During interview on 12/16/24 at 6:15 p.m. licensed practical nurse (LPN)-F stated we [nurses] have a 24-hour report where the evening supervisor writes the names of the residents after not having a BM for 7 shifts. We check this report, and after not having a BM for 9 shifts, our residents get prune juice or Miralax as needed. LPN-F added on the 4th day, the residents get a bisacodyl suppository. LPN-F talked to R60, and he requested a suppository. LPN-F verified based on POC BM task report, R60 had last BM on 12/12/24, therefore, there had been 13 shifts since resident had the last BM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 12/17/24 at 8:50 a.m., R60 stated yesterday he received a suppository and had a BM. R60 stated he had chronic issues with pain but had decided to stop taking Ultram (pain medication) because of his problems with constipation. R60 stated, I prefer to have pain rather than being constipated. Review of R60's MAR, printed on 12/17/24, indicated R60's Ultram had been discontinued on 12/6/24. During interview on 12/17/24 at 1:28 p.m., nursing assistant (NA)-B stated R60 sometimes complained of abdominal pain, and when he asks for prune juice, we give it to him, and report to the nurse before the end of her shift. During interview on 1/17/24 at 1:34 p.m., LPN-G stated R60 received scheduled Miralax and Senna twice a day. LPN-G stated the nurses followed the bowel protocol which directed them to use PRN Miralax. LPN-G added, we have standing orders for enemas, and we have suppositories as well. During interview on 12/17/24 at 1:57 p.m., nurse manager/LPN-A stated the 24-hour report was started by the overnight supervisor. The supervisor checks the resident's bowel records and writes the names of residents who didn't have a BM for 7 shifts. LPN-A stated if a resident doesn't have a BM in 9 shifts, they receive a suppository. LPN-A stated R60's senna order was increased in April and stated a couple of weeks ago, R60's scheduled Ultram was discontinued per his request because it seemed R60 had increased problems with constipation. During interview on 12/18/24 at 10:09 a.m., LPN-B stated everyday he looked at the bowel records in the computer and the 24-hour report. If a resident hasn't had a BM in 7 shifts, he will use the resident's PRN orders for constipation. LPN-B stated if a resident didn't have a BM for 9 shifts, he will follow the bowel protocol that directs nurses to administer a bisacodyl suppository. LPN-B stated all interventions, effectiveness of interventions and/or residents refusals needed to be documented in the MAR and residents' progress notes. During interview on 12/18/24 at 10:18 a.m., the director of nursing (DON) stated their bowel protocol indicated when a resident doesn't have a BM for 9 shifts, the resident will receive PRN Miralax or Senna. If they refuse these meds, they will receive a bisacodyl suppositories. If a resident refuses all interventions the primary physician needs to be notified. The DON stated all interventions need to be documented. DON verified R60 did not receive any PRN medications or a suppository after not having a BM for 11 shifts between 11/30 and 12/4, and once again after not having a BM for 13 shifts between 12/12 and 12/16. DON stated the nurses should have activated the bowel protocol after the 9th shift. DON also stated, based on documentation and medical history, R60 should have a more individualized bowel program. Facility's policy titled Bowel Management Protocol dated 12/2018, indicated nurses will routinely check the BM record to ensure residents have bowel movements according to standard of practice or as identified on the individualized care plan. This policy includes the Bowel Management Standing House Orders which read, Bowel Management Standing House Orders Constipation: if no documented BM in last 8 shifts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Ask Resident when their last BM occurred. If they can accurately report their last BM, place a progress note regarding last BM. * On shift 9 start pushing fluids (unless contraindicated or has a fluid restriction) and give a Bisacodyl suppository 10mg PR, document results. * If no results, then the next shift will give another Bisacodyl suppository 10mg PR, document results. * If no results, by the end of the shift, call practitioner for further orders.

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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** 40614 Based on observation, interview, and document review, the facility failed to comprehensively assess wounds including measurements weekly for 1 of 3 residents (R52) reviewed for pressure ulcers. Findings include: R52's Diagnosis Report, dated 12/18/24, included diagnoses of infection and inflammatory reaction to internal right knee prosthesis (artificial joint), type 2 diabetes mellitus with neuropathy (nerve pain), osteomyelitis (infection of the bone) of right ankle and foot, methicillin resistant staphylococcus aureus (type of bacteria that many antibiotics don't work on) and peripheral vascular disease (slow and progressive disorder of narrowing of blood vessels, usually in legs). R52's quarterly Minimum Data Set (MDS), dated [DATE], identified R52 was cognitively intact, was dependent on staff for toileting, bathing, and required, substantial to maximal assistance with bed mobility and transfers. The MDS documented R52 was high risk for pressure ulcers and currently had one unstageable pressure ulcer due to coverage of wound bed by slough (dead tissue) and/or eschar (thick, black, necrotic tissue that forms as a result of dead tissue). R52's physician orders dated 12/11/24, included wound care to left heel. Cleanse with wound cleanser, pat dry and apply betadine and cover with dry dressing. An order dated 7/25/24, included primary nurse to assess bilateral lower extremity wounds on Wednesdays; enter wound assessment with measurements entered into the progress note. R52's plan of care dated 9/6/24, included R52 had a risk for skin integrity impairment related to being admitted with multiple medical issues .and left heel pressure ulcer. Interventions included observe heel integrity daily, float heels off surface of bed, air mattress, ., follow facility protocols for treatment of injury and observe for signs of infection such as redness, swelling, pain, fever and purulent drainage. Report abnormal findings to provider. On interview and observation 12/16/24 at 3:03 p.m., R52 was lying in her bed with both heels elevated off bed with wedged cushion, on an air mattress. R52 stated she had a pressure ulcer on her left heel that she developed while at this facility. R52 added she has had amputation of several of her toes and had poor circulation. R52 stated her wound has remained unchanged and she has the wound specialist at the facility see her weekly on Wednesdays. R52's Braden scale (tool used to predict pressure ulcer risk) skin assessments were completed monthly beginning 5/1/24 through 11/26/24 with a continued score of 18 indicating at risk for pressure ulcers. Weekly wound assessments and measurements were completed weekly except 5/26/24, 7/4/24, 8/1/24, 8/7/24, 10/2/24, 10/17/24, 11/12/24, and 12/4/24 which were missing. On interview 12/18/24 at 7:23 a.m., registered nurse (RN)-E stated the wound care nurse is responsible for wound assessments and measurements weekly but if she is gone, R88's nurse was responsible to complete. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245343	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnesota Masonic Home Care Center	11501 Masonic Home Drive Bloomington, MN 55437

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On interview 12/18/24 at 8:12 a.m., licensed practical nurse (LPN)-A, also identified as nurse manager, stated the wound nurse is responsible for completing wound assessments and measurements and if she is gone, the wound nurse will put an order in for the nurse to complete. LPN-A was unsure why the above dates were missing and stated R88 has only been on this unit for 3 months and referred to wound care nurse to assist with locating them. On interview 12/18/24 at 8:44 a.m., registered nurse (RN)-D, also identified as wound care manager, stated she does wound rounds on R88 weekly and completes comprehensive wound assessment and measurements. RN-D stated she will place an order for nursing to complete the wound assessments and measurements when she is gone. RN-D added she may forget at times to document the wound assessments as she does a lot of wound care and assessments every day. RN-D indicated R88's left heel pressure wound was present on admission, is likely chronic and was unavoidable due to R88's poor arterial blood flow. RN-D stated the goal is to keep the wound from becoming infected and to keep it stable, which they have been able to do. A request was made for above dates that were missing wound assessments and measurements. On interview 12/18/24 at 11:25 a.m., RN-D indicated on 6/19/24, R88 saw her podiatrist and measurements and wounds were assessed at that time. RN-D confirmed the rest of the wound assessments and measurements were not able to be located. RN-D stated it was discovered when she was putting the order in for nursing staff to complete in her absence, it was entered incorrectly so it did not flow over as an order for the floor nurse to complete. RN-D confirmed these likely were not completed due to the error, which has now been corrected. On interview 12/18/24 at 10:33 a.m., the director of nursing (DON) confirmed wound assessments and measurements should be completed weekly. The DON indicated in the absence of the wound care nurse, the licensed nurse should be completing these. The DON indicated starting two weeks ago, the unit manager and licensed nurse are supposed to round with the wound care nurse so this should help improve communication. A Skin and Wound Management policy dated 10/23 included chronic wounds, wounds related to pressure, severe wounds and wounds with high microbial bioburden are followed by the wound care manager or designee who assesses the wound weekly. Wound care is coordinated in collaboration with members of the interdisciplinary team, which include the wound care manager, nurse manager, therapy, MDS coordinator, nurse, nursing assistant and/or dietician. At each weekly wound assessment, a progress note is written to document a description of the wound, any changes from the week prior, pain with wound care, and any new interventions or changes in plan of care.