

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245417	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/02/2024
NAME OF PROVIDER OR SUPPLIER  The Villas at Robbinsdale		STREET ADDRESS, CITY, STATE, ZIP CODE  3130 Grimes Avenue North Robbinsdale, MN 55422	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 28598</p> <p>Based on observation, interview, and record review the facility failed to ensure 1 of 1 residents (R1) reviewed for skin alterations had weekly skin observations completed, in addition to informing the interdisciplinary team of R1's skin breakdown.</p> <p>Findings include:</p> <p>R1's quarterly minimum data set (MDS) dated [DATE], indicated R1 had peripheral vascular disease, diabetes with neuropathy (lack of sensation caused by nerve damage) and was cognitively intact. The MDS further indicated R1 was dependent for toileting, hygiene, and required maximum assistance by 2 staff for mobility and transfers.</p> <p>R1's Care Plan dated 7/08/24, indicated R1 had the potential for alteration in skin integrity. Staff were to monitor skin integrity daily during cares and perform weekly skin inspections and provide treatment to open areas per physician order.</p> <p>R1's Risk vs Benefits form dated 8/12/24, indicated staff were to ensure pressure offloading and position changing and incontinence care occurred related to the concern for skin breakdown. They were to discuss with R1 that refusal to off load or allow staff to change R1 had the potential of skin breakdown. The form indicated the provider was updated and the resident understood the risk and agreed to comply.</p> <p>An Interdisciplinary Team (IDT) Care Conference Note dated 9/18/24, indicated therapy was working with getting R1 a wheelchair and prosthetic legs. Transfers required 2 staff using a total mechanical lift (Hoyer) for bed mobility. R1 could dress the top half of their body independently, however, R1 needed assistance with the lower half and also assistance with hygiene needs. Staff noted during conversation with therapy, R1's family member brought up How about the wound on her bum? Therapy replied, what wound? If she would get a wound, it would be because she is not getting change timely when she goes on long LOA [leave of absence]. After therapy said this, [family member] went quiet. IDT noted they explained how not being changed can cause skin break down in the peri (personal) area.</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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility progress note dated 9/21/24, indicated at 10:30 p.m. R1 returned from their LOA in stable condition. R1 was alert and appropriately responded to conversations, vital signs at baseline parameters . right posterior thigh multiple scattered excoriated [skin abrasion] skin present, barrier cream applied, some excoriated skin present on left posterior [back] of thigh, barrier cream applied . continue to monitor. No further notes were documented on any cares provided on skin breakdown for R1.</p> <p>An updated Care Plan was provided while on survey dated 10/02/24, indicated R1 had a small open area on their right thigh. The care plan directed staff to monitor for skin breakdown and signs/symptoms of infections. Staff were to report signs/symptoms to MD (medical doctor). In addition the care plan indicated on 10/02/24 a new wheelchair cushion was added to R1's wheelchair from therapy.</p> <p>During observation and interview on 10/02/24 at 10:45 a.m., R1 was in her room in her wheelchair and stated she her bottom hurts from sitting in her chair. Occupational Therapist (OT)-A entered her room and stated she was not aware of R1 having any open areas or skin break down. OT-A stated she has a two inch cushion on her wheelchair and would look for a different one that might be more comfortable for her.</p> <p>During interview on 10/02/24 at 12:38 p.m. with registered nurse (RN)-A stated he completed R1's skin assessment on 9/27/24 and her excoriation on her bottom had improved. R1 also has an area between her legs she keeps scratching at. R1 went to dialysis three times a week, and also visited her family and stayed for long periods of time and returned incontinent of urine to the point where her pad is dripping with urine.</p> <p>During interview on 10/02/224 at 1:12 p.m., director of nursing (DON) stated R1 had no open area on her bottom, just excoriation. The DON stated R1 had signed a risk vs benefit form on 8/12/24, and he explained to her the risk of sitting long periods of time with family and not getting changed when she is out on LOA.</p> <p>During observation and interview on 10/02/24 at 2:52 p.m. , RN-A and RN-B were in R1's room completing a skin assessment on R1. On the left side of R1's lower buttock area was a excoriated redden area with a 0.5 centimeter (cm) by 0.2 cm area RN-B had measured, with surrounding pinkish-red skin around the measured area. RN-A stated he noticed the concern on 9/27/24, when completed the skin assessment and felt R1 might be sitting too long and R1 had been scratching the area and complained of her bottom hurting while in her wheelchair.</p> <p>During interview on 10/02/24 at 3:42 p.m. with the facility nurse consultant (NC) who stated the DON is required to read progress notes on a daily basis and then bring up at daily interdisciplinary team meeting (IDT). If there were skin concerns, therapy would then be alerted of R1's skin excoriation and could then provide a different w/c cushion. In addition, the NC stated R1's care plan should have addressed the skin excoriation and risk of sitting long periods of time with family members. Nursing staff had never measured the excoriated area and should have in order to see if the area was improving or worsening.</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>The Skin Assessment &amp; Wound Management policy revised March of 2024, indicated for non-pressure wounds and altered skin integrity, staff were to notify the provider who ordered treatment, notify the residents representative, complete education with resident and/or the resident's representative including the risks &amp; benefits, initiate any skin and wound evaluation, notify the nurse manager and/or wound nurse, make any referrals to therapies if appropriate, review and update the care plan including interventions, and identify risks for skin breakdown.</p>		