DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: ZN4M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00798

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245358**

2.STATE VENDOR OR MEDICAID NO.
(L2) **764975000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HILLTOP CARE CENTER**
(L4) **410 LUELLA STREET**
(L5) **WATKINS, MN** (L6) **55389**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **05/01/2002**

6. DATE OF SURVEY **10/14/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Kathryn Serie, Unit Supervisor — 10/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/21/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 11/30/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/28/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245358
November 21, 2016

Mr. Fred Struzyk, Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

Dear Mr. Struzyk:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 28, 2016 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 21, 2016

Mr. Fred Struzyk, Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

RE: Project Number S5358025

Dear Mr. Struzyk:

On October 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 22, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 4, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 28, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 22, 2016, effective October 28, 2016 and therefore remedies outlined in our letter to you dated October 7, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245358 Y1	A. Building B. Wing Y2	11/4/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 10/28/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 10/28/2016	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 10/28/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 11/21/2016	SIGNATURE OF SURVEYOR 03048	DATE 11/04/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/22/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245358	A. Building 01 - MAIN BUILDING 01 B. Wing	10/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/22/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 11/21/2016	SIGNATURE OF SURVEYOR 19251	DATE 10/13/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/21/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

November 4, 2016

Mr. Fred Struzyk, Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

Subject: Hilltop Care Center - Informal Dispute Resolution (IDR)
Provider # 245358
Project # S5358025

Dear Mr. Struzyk:

This is in response to your letter of October 18, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F329 S/S-D § 483.25(l), issued pursuant to the survey event ZN4M11, completed on September 22, 2016.

The information presented with your letter, the CMS 2567 dated September 22, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F329 S/S – (D) 42 CFR § 483.25(l) Unnecessary Drugs
(Rev. 130; Issued: 12-12-14, Effective: 12-12-14, Implementation: 12-12-14)
1. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:
(i) In excessive dose (including duplicate therapy); or (ii) For excessive duration; or
(iii) Without adequate monitoring; or
(iv) Without adequate indications for its use; or
(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
(vi) Any combinations of the reasons above.

Summary of the facility's reason for IDR of this tag: The facility disputed the finding based on the surveyor's request for information with specific date parameters of 3/15/16 to exit date of 9/22/16 in regards to a physician ordered annual Lipid Panel blood test in order to determine whether the current use of Simvastatin (a cholesterol lowering medication) was effective. The facility provided a copy of a Lipid Profile which had been completed on 3/14/16 (previous Lipid Profile dated 3/15/15.)

Summary of findings: R34 had received daily Simvastatin medication for several years. R34's physician had ordered a Lipid Profile to be done annually. A Lipid Profile was completed on 3/15/15 and again on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "Revised CMS2567 as a result of an Informal Dispute Resolution."	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		10/28/16

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

Electronically Signed | 10/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to immediately notify the physician of the open wounds located on the bony prominence's of the spine 1 of 1 resident (R18) reviewed who developed pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers (PU) and no pressure ulcer present. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine for R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left	F 157	Resident 18's physician was notified on 9/6/16 regarding pressure ulcers. Physician is updated on wound progress on rounds and if wound shows no progress in 2 weeks or if wound deteriorates. Staff was provided education on wounds and to notify the physician upon discovery of a wound. DON or designee will audit residents with pressure ulcers to ensure the physician is notified upon discovery and as needed. The DON will present to the Quality Assurance Committee the audit findings on physician notification and the Quality Assurance Committee will determine continuing periodic auditing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing was applied to the lower spine; three bony prominence's with skin breakdown were: (#1) upper wound on spine has pinkness that is resolving, (#2) middle wound located on the spine measured 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during sitz baths; Sitz baths were discontinued 8/15/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician was notified of the identified PU on 9/6/16 even though it was first identified on 8/16/16 and documentation dated 8/22/16, indicated the wound located on the upper part of the spine was due to deep tissue injury and the lower wound was documented as unstageable PU. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open area present to bony prominence's to back. Interventions included: air mattress on bed,	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spinal column. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)-D stated she thought the sores started as a result of R18 sitting on the toilet for longer periods of time due to sitz baths. RN-D confirmed the sitz baths were discontinued on 8/15/16; however, the PU's were first identified on 8/16/16, and the physician was not notified until 9/6/16. RN-D verified the physician should have been notified sooner.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and monitor	F 309	Resident's 15 and 41 have daily monitoring of bruises documented in their	10/28/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 4 significant bruising for 3 of 3 residents (R15, R41, R60) reviewed for non- pressure related skin problems and failed to assess, revise and implement timely interventions to promote healing for 1 of 1 resident (R24) reviewed who had a bunion wound. Findings include: R15 Current diagnosis listed on the care plan dated 7/12/16, for R15 included chronic obstructive pulmonary disease (COPD), hypothyroid, hypertension, dementia, obesity and atrial fibrillation. The Minimum Data Set (MDS) assessment dated 8/10/16, indicated R15's Brief Interview of Mental Status (BIMS) score was 15, indicating no cognitive impairment. On 9/19/16, at 3:53 p.m. R15 was observed to have large bruises on both forearms, hands and knees. R15 had arm protectors donned and indicated she has a skin tear located on the left elbow. It was noted that a dressing covered a part of the wound. When interviewed at this time, R15 explained, "those are all from the hospital, they just roll you over, they don't care." During further observation of R15's arms, the following was noted: The left arm had a Vaseline dressing over a skin tear located at the left elbow area, which was wrapped with a soft gauze. The arm had bruising which appeared dark maroon to dark purple in color. This bruising extended around the circumference of the arm from the fingers extending to the area above the elbow, 4.5 inches. The backside (posterior) of the upper arm had a rectangle shaped bruise which measures 3.5 x 5 inches. Bruising was noted on the tops of both hands, covering the entire surface. The right	F 309	electronic medical record. Resident 60 discharged. Resident 24 has daily monitoring of bunion wound in electronic medical record. Staff was provided education on daily monitoring of bruises and non-pressure related wounds and when to notify physician. DON or designee will audit residents with bruises and non-pressure related wounds weekly to ensure that daily documentation is completed. The DON will present to the Quality Assurance Committee the audit findings on bruise and non-pressure related wound documentation and the Quality Assurance Committee will determine continuing periodic auditing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

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F 309	Continued From page 5 arm had bruising which started at the top of the hand, circumferences the arm at the wrist and extended to above the elbow approx. 2 inches. The outer forearm revealed an uncovered open wound, measuring 1.5 x 2 inches. The wound bed appeared to be open and a ½ inch opening with a weepy base was evident through the dermis. The surrounding tissue was very dry and the skin was peeling. Review of the current care plan dated 7/12/16, identified R15 at risk for skin breakdown due to decreased mobility and incontinence; ulcer present to right forearm from a hematoma and skin tear to the left elbow. Interventions indicated R15 bruises easily, had been on Coumadin (blood thinner), only on aspirin now and to apply a protective sleeve daily. Documentation in the record revealed R15 was hospitalized from 9/6/16-9/16/16 for treatment of sepsis and pneumonia. The hospital transfer form dated 9/16/16, identified that R15 had large dark bruising to the body; involving the arms, hands, knees, sides of breasts and abdomen. Documentation indicated R15 had been on Coumadin and aspirin prior to hospitalization but was discharged on aspirin only. Review of the admission assessment dated 9/16/16, also identified that R15 had extensive bruising to both upper extremities, faded to right knee, bruising to dorsal hands and a large skin tear to the left elbow which was L shaped, measuring 7 centimeters and 3 centimeters in length. Steri-strips and a secondary dressing were applied. When interviewed on 9/22/16, at 12:03 p.m.	F 309		

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registered nurse (RN)-A stated R15 returned from the hospital stay with bruising to bilateral (both) upper extremities, fading bruises on the right knee and bruising to dorsal (posterior) hands. She confirmed documentation was not available to review related to any ongoing assessment and/or status of the extensive bruising.

R41
R41 had diagnoses according to the face sheet dated 9/22/16, which included dementia with Lewy body disease (2/8/16) and history of multiple falls. R41 returned from the hospital on 9/16/16 with bruising noted to bilateral upper and lower extremities; bruising faded to right knee, bruising to dorsal hands, purplish color from shins to toes.

On 9/20/16, at 10:48 a.m. R41 was observed to have bruises on both elbows, top of both lower arms, both wrists and both hands. These bruises were dark purplish to maroon in color and varied in size. Interview with R41 at this time indicated he was unsure of when or how he obtained these bruises. The identified bruises varied in size on both arms, wrists and hands. The top of the right hand revealed one bruise 1.5 inches between the second and third finger. On the top surface of the right hand there was another 2 inch bruise. The top of the wrist had a 3 inch bruise, (involving the sides of the wrist). The forearm had 3 more bruises: 2 x 3 inches, 1 x 1 inch and 2 x 3 inches. Located above the elbow was a 3 x 4 inch dark purple bruise. On top of the left hand were two 1 inch bruises and the left forearm had 2 bruises measuring 3.5 x 4 inches.

Review of the current care plan 9/4/16, identified R41 had experienced 12 falls in the last 3

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months. The care plan intervention identified the spouse brought in long sleeve shirts for R41 to wear to reduce the risk of skin tears with falls. The care plan also revealed that arm protector sleeves have been attempted but R41 kept removing them so they were discontinued.

When interviewed on 9/22/16, at 12:23 p.m. RN-B indicated she was aware of R41's bruises on the arms, wrists and hands. RN-B further indicated R41 always has some kind of bruising on his arms and confirmed these bruises had not been monitored on the treatment sheets nor in any other format. RN-B confirmed she had never seen any monitoring for bruises while working at the facility.

Interview with RN-D on 9/21/16, at 12:27 p.m. confirmed R41 frequently has bruises on his arms and hands from falls. She further indicated that staff have attempted in the past to don sleeve protectors, but R41 removed them. RN-D confirmed staff had not had a system for monitoring any of R41's bruises for healing and/or deterioration.

R60
It was observed on 9/19/16, at 11:49 a.m. that R60 had significant bruising on his arms. R60's hands and arms had dark purple to maroon color bruises. The top of his right hand revealed two 1.5 inch bruises. The forearm had 4 x 4 inch bruises which involved the circumference of the arm. Located above the elbow was a 3 x 4 inch bruise. The left arm revealed two 1 inch bruises and the forearm had one 3 x 4 inch bruise and two 1.5 inch bruises. The bruises were all dark purple to maroon in color. Interview with R60 at the time indicated he was unsure of how he got

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them but shared he has a history of easily bruising. The quarterly assessment dated 7/7/16, indicated R60 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment.

Review of the R60 current care plan dated 7/14/16, identified him as having a potential for skin alteration due to the dying process and end of life and decreased mobility. The care plan revealed diagnosis which included: atrial fibrillation, malignant neoplasm of the lung, anemia due to chemotherapy and chronic kidney disease. Review of the bath audit skin observations for July, August, and September 2016 identified there was no documentation related to the significant bruising evident on R60's arms.

During an interview on 9/22/16, at 10:17 a.m. RN-B stated that upon discovery of a new wound, a bruise and/or a skin tear, an alert is created by the nursing assistant in the software system. The alert is electronically sent to the charge nurse which subsequently triggers an assessment, treatment and/or monitoring program. RN-B confirmed that monitoring bruising to identify deterioration and/or healing would be a good idea.

During an interview 9/22/16, at 10:10 a.m. RN-D confirmed there was no system to monitor the significant bruising on the arms of R60. RN-D stated that R60 has experienced bruising since admission on 3/16/16.

When interviewed on 9/22/16, at 12:12 p.m. the director of Nursing (DON) confirmed there is not a system implemented to monitor skin bruising.

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DON stated that if there was a change in condition of a wound it would be documented in the progress notes but there was no current process for daily/weekly skin monitoring. She confirmed there is no policy to address monitoring of non-pressure related wounds or bruises.

During a subsequent interview with the DON on 9/22/16, at 1:00 p.m. the DON presented a picture of a monitoring system to be set up in the facility software and indicated she would implement this system for monitoring and assessing resident bruises after staff were educated.

Review of the facility skin care policy dated 5/2011, indicates skin problems are identified and treatments instituted promptly. A registered nurse oversees each residents skin care in accordance with the comprehensive assessment/care plan. The facility staff receive education on skin care and standard protocol to assure accurate documentation and timely interventions for skin care or problems.

R24

Review of R24's admission assessment dated 7/28/16, identified that R24 had a 0.2 cm by 0.2 cm open area to callused area on left bunion; Scant weeping drainage and bilateral bunion with approximately 1 cm pinkness was present. Foam dressings were placed on both bunion for protection at the time of admission, (7/28/16).

The admission MDS assessment dated 8/4/16, identified a Brief Interview of Mental Status (BIMS) score of 14 (intact cognition), extensive assistance of two staff with bed mobility/transfers, at risk for PU and the presence of a lesion on the foot. The CAA dated 8/4/16, included: no

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pressure ulcers, a scab to hammer toe and bunion and the care plan indicated a turn/repositioning schedule every 2 hours and monitor skin.

Review of the shower day worksheet audits for R24 were as noted:
(1) 8/1/16-small area to left bunion,
(2) 8/5/16- open left bunion,
(3) 8/12/16-bunion pink, sore to left bunion and
(4) 8/19/16-open left bunion.
The nurse progress notes dated 8/19/16, included: open area to left bunion despite padding with foam dressing; red round with well-defined edges; no pressure noted from shoes; no infection symptoms; and foam dressing replaced with skin prep to wound edges. A "get acquainted visit" physician note dated 8/10/16, did not identify the presence of a bunion nor any open area.

A fax sent to the physician dated 8/19/16, at 4:38 p.m. identified: small open area to left bunion despite adding foam padding to area; measured 0.5 cm by 0.5 cm.; and continue foam dressing. The fax was noted, signed by the physician and faxed back to the facility on 8/22/16, at 1:52 p.m. The 8/19/16, wound observation tool identified the open area as: measurement-0.5 cm by 0.5 cm moist area with 100% granulation tissue. The treatment was to continue adhesive foam dressing every 3 days.

A nurses progress note dated 8/25/16, identified: foam dressing was replaced to left bunion; an additional sore was noted to the left bunion; and a total of two open areas were noted to bunion. No measurements were documented. The wound observation tool dated 8/25/16, identified: area

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worsening, measured 0.5 cm by 0.5 cm, and moist with 100% granulation.

A nurses note dated 8/31/16, indicated R24 had an appointment scheduled with the podiatrist on 8/31/16, but the appointment was canceled and rescheduled for 9/8/16 due to R24 not feeling well. The wound observation tool dated 9/1/16, identified the area as worsening with 50% granulation tissue and 50% slough tissue and measuring 0.8 cm by 1.3 cm. The current treatment plan was to continue foam dressing changes 2 times per week. The evaluation identified worsened sore. Although the wound was noted to worsen according to the documentation dated 8/25/16 and 9/1/16, no revisions and/or reassessments occurred to ensure healing occurred.

During interview on 9/21/16, at 8:03 a.m. R24 stated the bunion was not sore initially but the more she had therapy the more it started to hurt. She stated, "you are working your shoe all the time and it hurt." R24 received physical therapy until 9/9/16. Documentation was lacking to indicate the plan of care was revised to address the offloading of the foot to remove pressure from R24's regular shoe.

Review of a podiatry visit note dated 9/8/16, identified a full thickness ulceration over the left foot bunion, approximately 1 cm in diameter. The ulceration was debrided and a dressing and surgical shoe utilized. New orders were written for Bacitracin ointment, gauze and kling wrap to foot, surgical shoe (open toe shoe) to offload ulcer and return in 4 weeks. The wound evaluation tool dated 9/9/16, identified: 75 % granulation tissue, 25 % slough tissue,

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measurement-0.8 cm by 1.2 cm and treatment of Bacitracin, gauze and kerlex daily change.

A physician visit note dated 9/14/16, identified the ulceration on the bunion as measuring 0.6 cm by 0.6 cm and pink around the edge. The wound observation tool dated 9/16/16, identified: area unchanged, 10 % granulation tissue and 90 % slough tissue and measurements-0.9 cm by 0.9 cm and 0.1 cm depth. Current treatment identified as Bacitracin and gauze wrap daily.

A nursing progress note dated 9/17/16, at 2:34 p.m. identified the area on R24's left foot ulcer as being red, warm to touch , macerated/non-blanch-able with R24 expressing pain to area with palpation. Nursing progress noted dated 9/17/16, at 9:50 a.m. identified increased drainage noted to left foot at bunion site. The dressing was saturated with drainage with soaked through R24's socks. The site was identified at red and warm to touch with purulent drainage.

A nursing progress note dated 9/19/16, identified that R24 was receiving the antibiotic medication Cipro for a possible urinary tract infection (a urine culture was pending, but no growth after one day). A fax from the physician dated 9/19/16, indicated to continue Cipro which would cover the foot infection and a culture of the open area on bunion was ordered.

Documentation on R24's wound evaluation tool dated 9/21/16, identified: area worsening, 100 % slough tissue, 0.7 cm by 0.8 cm by 0.9 cm depth, infection suspected and purulent drainage present. Treatment: Bacitracin, Adaptic, gauze and kerlex, started on Cipro 500 mg (antibiotic)

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F 309	Continued From page 13 twice daily on 9/16/16; bunion became inflamed 9/17/16 and culture was obtained on 9/19/16. During interview on 9/22/16, at 12:21 p.m. registered nurse (RN)-D verified the left bunion of R24 had an open area when admitted (7/28/16) and the physician was notified of the open area by fax on 8/19/16. The physician responded to the fax on 8/22/16 with "noted". RN-D verified the physician should have been notified of the open area when identified on admission. She stated "we just covered it with a foam dressing; [R24's] shoes didn't seem tight like they were adding pressure or anything."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to provide the appropriate treatment to prevent further deterioration of pressure ulcers for 1 of 1 (R18) resident reviewed with facility acquired pressure ulcers. Findings include:	F 314	Resident 18 had reassessment of both sitting and lying assessments. Resident 18 had OT evaluation to review positioning and make recommendations. Resident 18's plan of care was updated. Staff was provided education on pressure ulcers and facility policy on treatment of pressure ulcers. DON or designee will	10/28/16

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F 314	Continued From page 14 R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers, no pressure ulcer (PU) identified, is turned a minimum of every 6 hours and tolerates this per assessment. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine of R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing applied to lower spine. Three bony prominence's were identified with skin breakdown: (#1) upper wound has pinkness that is resolving, (#2) middle wound has 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during Sitz baths; Sitz baths were discontinued 8/15/16. During observation on 9/20/16, at 2:07 p.m. R18 was lying supine (on back) in bed. At 2:37 p.m. R18 was resting in bed facing the window. R18 had a pillow positioned behind her back and a wedge under legs. At 3:31 p.m. she remained in the same position but lying more on her back than side. On 9/21/16, at 7:00 a.m. R18 was observed in the	F 314	audit residents with pressure ulcers weekly to ensure that assessments are completed and facility policy is followed. The DON will present to the Quality Assurance Committee the audit findings on pressure sores and the Quality Assurance Committee will determine continuing periodic auditing.	

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bathroom seated on the toilet with EZ stand hooked up. R18's back was resting/pressing against the toilet seat cover. R18's spine was curved and kyphotic. At approximately 7:15 a.m. R18 was assisted from the toilet and transferred into the wheel chair which had a thin piece of lambs wool over the back. At 9:30 a.m. R18 was observed seated in a recliner. At 10:20 a.m. registered nurse (RN) A was observed doing a wound treatment to R18's spine. The top wound (#1) was reddened and did not appear open, the middle area (#2) had an open area and the bottom (#3) open area was covered with slough. R18 had a rolled bath blanket behind her lower back. RN-A stated this was to relieve pressure from her back and had just (9/20/16) been implemented. At 1:26 p.m. R18 was observed on the toilet hooked up to EZ stand. R18's back/spine was again pressing up against the toilet seat cover until she was assisted back to bed at approximately 1:36 p.m. There was no padding/protection between the resident and the hard surface.

On 9/22/16, at 12:43 p.m. R18 was seated on the toilet, hooked up to EZ stand. R18's kyphotic appearing back/spine remained pressed against the toilet seat cover. R18 was taken off the toilet and put to bed at approximately 12:55 p.m.

The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound (#1) as a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower spine wound (#3) as an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough

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F 314	Continued From page 16 (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open areas present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. No reassessments were conducted and/or interventions revised after noted skin breakdown. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spine. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine. The wound observation tool for R18 dated 9/9/16, identified the spine wound located on the lower area (#3) as being a Stage III PU (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Documentation indicated the physician was notified of the identified pressure ulcers on 9/6/16. The wound observation tool dated 9/21/16, identified the upper wound on the spine (#1) as being a Stage II PU and the lower spine (#3) wound as a Stage III PU. During interview on 9/22/16, at 12:43 p.m. nursing assistant (NA) A verified R18's back	F 314		

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F 314	Continued From page 17 [bony prominence] does press against the toilet seat while seated on the toilet. She stated she routinely sits for 5-10 minutes at a time in this position. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)- D stated she thought the sores started from R18 sitting on the toilet for longer periods of time due to having sitz baths. She stated the sitz baths were discontinued on 8/15/16, but she could not identify when the sitz baths were started. She stated she thought they had been doing them maybe 2 weeks before they discontinued them. She verified the pressure areas were identified on 8/16/16, and stated she put a foam dressing on right away. She stated the lambs wool placed on the wheel chair was implemented this week and the rolled bath blanket behind back in recliner had been implemented on 9/19/16. RN-D further stated I didn't really think about them being from pressure and also confirmed that all three areas on the spine were open again. RN-D stated the top one (#1) was healed on Friday (9/16/16) but had re-opened. RN-D verified R18 still had pressure to the open areas/bony prominence when toileted and resting against the seat due to her kyphosis. She verified R18 would have pressure on her back from the toileting and sitting. She stated R18 had not been reassessed for positioning since the PU developed and repositioning every 6 hours would not be adequate as defined in the plan of care.	F 314		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

October 27, 2016

Mr. Fred Struzyk, Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

Subject: Hilltop Care Center - Informal Dispute Resolution (IDR) for Licensing orders
Provider # 245358 Project # S5358025

Dear Mr. Struzyk:

This is in response to your letter received on 10/11/16, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F329 where corresponding correction orders were issued pursuant to the survey completed on September 22, 2016.

The information presented with your letter, the CMS and State 2567s dated September 22, 2016, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

1540 - MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring

Refer to summary outlined in the MDH letter dated October 27, 2016, addressing the IDR for federal deficiencies.

This is not a valid correction order and will be removed from the 2567 State Form.

The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

Please note it is your responsibility to share the information contained in this letter and the results of this review with the President of your facility's Governing Body.

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-206-2731 Fax: 507-206-2731
gary.nederhoff@state.mn.us

cc: Office of Ombudsman for Long-Term Care
Maria King, APM, Assistant Program Manager
Licensing and Certification File
Gary Nederhoff, St. Cloud Team A District Office Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00798	A. BUILDING: _____ B. WING _____	09/22/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 19-22, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. "Revised STATE FORM as a result of an Informal Dispute Resolution."	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		10/28/16

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to immediately notify the physician of the open wounds located on the bony prominence's of the spine 1 of 1 residents (R18) reviewed who developed pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers (PU) and no pressure ulcer present. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine for R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing was applied to the lower spine; three bony prominence's with skin breakdown were: (#1) upper wound on spine has pinkness that is resolving, (#2) middle	2 265	Corrected.	

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2 265	Continued From page 4 wound located on the spine measured 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during sitz baths; Sitz baths were discontinued 8/15/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician was notified of the identified PU on 9/6/16 even though it was first identified on 8/16/16 and documentation dated 8/22/16, indicated the wound located on the upper part of the spine was due to deep tissue injury and the lower wound was documented as unstageable PU. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open area present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spinal column.	2 265		

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2 265	Continued From page 5 R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)-D stated she thought the sores started as a result of R18 sitting on the toilet for longer periods of time due to sitz baths. RN-D confirmed the sitz baths were discontinued on 8/15/16; however, the PU's were first identified on 8/16/16, and the physician was not notified until 9/6/16. RN-D verified the physician should have been notified sooner. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop and monitor policies and procedures to ensure practioners are notified of changes in residents condition accurately. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		10/28/16

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2 830	Continued From page 6 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and monitor significant bruising for 3 of 3 residents (R15, R41, R60) reviewed for non- pressure related skin problems and failed to assess, revise and implement timely interventions to promote healing for 1 of 1 resident (R24) reviewed who had a bunion wound. Findings include: R15 Current diagnosis listed on the care plan dated 7/12/16, for R15 included chronic obstructive pulmonary disease (COPD), hypothyroid, hypertension, dementia, obesity and atrial fibrillation. The Minimum Data Set (MDS) assessment dated 8/10/16, indicated R15's Brief Interview of Mental Status (BIMS) score was 15, indicating no cognitive impairment. On 9/19/16, at 3:53 p.m. R15 was observed to have large bruises on both forearms, hands and knees. R15 had arm protectors donned and indicated she has a skin tear located on the left elbow. It was noted that a dressing covered a part of the wound. When interviewed at this time, R15 explained, "those are all from the hospital, they just roll you over, they don't care." During further observation of R15's arms, the following was noted: The left arm had a Vaseline dressing over	2 830	Corrected.	

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2 830	Continued From page 7 a skin tear located at the left elbow area, which was wrapped with a soft gauze. The arm had bruising which appeared dark maroon to dark purple in color. This bruising extended around the circumference of the arm from the fingers extending to the area above the elbow, 4.5 inches. The backside (posterior) of the upper arm had a rectangle shaped bruise which measures 3.5 x 5 inches. Bruising was noted on the tops of both hands, covering the entire surface. The right arm had bruising which started at the top of the hand, circumferences the arm at the wrist and extended to above the elbow approx. 2 inches. The outer forearm revealed an uncovered open wound, measuring 1.5 x 2 inches. The wound bed appeared to be open and a ½ inch opening with a weepy base was evident through the dermis. The surrounding tissue was very dry and the skin was peeling. Review of the current care plan dated 7/12/16, identified R15 at risk for skin breakdown due to decreased mobility and incontinence; ulcer present to right forearm from a hematoma and skin tear to the left elbow. Interventions indicated R15 bruises easily, had been on Coumadin (blood thinner), only on aspirin now and to apply a protective sleeve daily. Documentation in the record revealed R15 was hospitalized from 9/6/16-9/16/16 for treatment of sepsis and pneumonia. The hospital transfer form dated 9/16/16, identified that R15 had large dark bruising to the body; involving the arms, hands, knees, sides of breasts and abdomen. Documentation indicated R15 had been on Coumadin and aspirin prior to hospitalization but was discharged on aspirin only. Review of the admission assessment dated	2 830		

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2 830	Continued From page 8 9/16/16, also identified that R15 had extensive bruising to both upper extremities, faded to right knee, bruising to dorsal hands and a large skin tear to the left elbow which was L shaped, measuring 7 centimeters and 3 centimeters in length. Steri-strips and a secondary dressing were applied. When interviewed on 9/22/16, at 12:03 p.m. registered nurse (RN)-A stated R15 returned from the hospital stay with bruising to bilateral (both) upper extremities, fading bruises on the right knee and bruising to dorsal (posterior) hands. She confirmed documentation was not available to review related to any ongoing assessment and/or status of the extensive bruising. R41 R41 had diagnoses according to the face sheet dated 9/22/16, which included dementia with Lewy body disease (2/8/16) and history of multiple falls. R41 returned from the hospital on 9/16/16 with bruising noted to bilateral upper and lower extremities; bruising faded to right knee, bruising to dorsal hands, purplish color from shins to toes. On 9/20/16, at 10:48 a.m. R41 was observed to have bruises on both elbows, top of both lower arms, both wrists and both hands. These bruises were dark purplish to maroon in color and varied in size. Interview with R41 at this time indicated he was unsure of when or how he obtained these bruises. The identified bruises varied in size on both arms, wrists and hands. The top of the right hand revealed one bruise 1.5 inches between the second and third finger. On the top surface of the right hand there was another 2 inch bruise. The top of the wrist had a 3 inch bruise, (involving the sides of the wrist). The forearm had 3 more	2 830		

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2 830	Continued From page 9 bruises: 2 x 3 inches, 1 x 1 inch and 2 x 3 inches. Located above the elbow was a 3 x 4 inch dark purple bruise. On top of the left hand were two 1 inch bruises and the left forearm had 2 bruises measuring 3.5 x 4 inches. Review of the current care plan 9/4/16, identified R41 had experienced 12 falls in the last 3 months. The care plan intervention identified the spouse brought in long sleeve shirts for R41 to wear to reduce the risk of skin tears with falls. The care plan also revealed that arm protector sleeves have been attempted but R41 kept removing them so they were discontinued. When interviewed on 9/22/16, at 12:23 p.m. RN-B indicated she was aware of R41's bruises on the arms, wrists and hands. RN-B further indicated R41 always has some kind of bruising on his arms and confirmed these bruises had not been monitored on the treatment sheets nor in any other format. RN-B confirmed she had never seen any monitoring for bruises while working at the facility. Interview with RN-D on 9/21/16, at 12:27 p.m. confirmed R41 frequently has bruises on his arms and hands from falls. She further indicated that staff have attempted in the past to don sleeve protectors, but R41 removed them. RN-D confirmed staff had not had a system for monitoring any of R41's bruises for healing and/or deterioration. R60 It was observed on 9/19/16, at 11:49 a.m. that R60 had significant bruising on his arms. R60's hands and arms had dark purple to maroon color bruises. The top of his right hand revealed two 1.5 inch bruises. The forearm had 4 x 4 inch	2 830		

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2 830	Continued From page 10 bruises which involved the circumference of the arm. Located above the elbow was a 3 x 4 inch bruise. The left arm revealed two 1 inch bruises and the forearm had one 3 x 4 inch bruise and two 1.5 inch bruises. The bruises were all dark purple to maroon in color. Interview with R60 at the time indicated he was unsure of how he got them but shared he has a history of easily bruising. The quarterly assessment dated 7/7/16, indicated R60 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the R60 current care plan dated 7/14/16, identified him as having a potential for skin alteration due to the dying process and end of life and decreased mobility. The care plan revealed diagnosis which included: atrial fibrillation, malignant neoplasm of the lung, anemia due to chemotherapy and chronic kidney disease. Review of the bath audit skin observations for July, August, and September 2016 identified there was no documentation related to the significant bruising evident on R60's arms. During an interview on 9/22/16, at 10:17 a.m. RN-B stated that upon discovery of a new wound, a bruise and/or a skin tear, an alert is created by the nursing assistant in the software system. The alert is electronically sent to the charge nurse which subsequently triggers an assessment, treatment and/or monitoring program. RN-B confirmed that monitoring bruising to identify deterioration and/or healing would be a good idea. During an interview 9/22/16, at 10:10 a.m. RN-D confirmed there was no system to monitor the significant bruising on the arms of R60. RN-D	2 830		

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2 830	Continued From page 11 stated that R60 has experienced bruising since admission on 3/16/16. When interviewed on 9/22/16, at 12:12 p.m. the director of Nursing (DON) confirmed there is not a system implemented to monitor skin bruising. DON stated that if there was a change in condition of a wound it would be documented in the progress notes but there was no current process for daily/weekly skin monitoring. She confirmed there is no policy to address monitoring of non-pressure related wounds or bruises. During a subsequent interview with the DON on 9/22/16, at 1:00 p.m. the DON presented a picture of a monitoring system to be set up in the facility software and indicated she would implement this system for monitoring and assessing resident bruises after staff were educated. Review of the facility skin care policy dated 5/2011, indicates skin problems are identified and treatments instituted promptly. A registered nurse oversees each residents skin care in accordance with the comprehensive assessment/care plan. The facility staff receive education on skin care and standard protocol to assure accurate documentation and timely interventions for skin care or problems. R24 Review of R24's admission assessment dated 7/28/16, identified that R24 had a 0.2 cm by 0.2 cm open area to callused area on left bunion; Scant weeping drainage and bilateral bunion with approximately 1 cm pinkness was present. Foam dressings were placed on both bunion for protection at the time of admission, (7/28/16). The admission MDS assessment dated 8/4/16,	2 830		

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	00798	A. BUILDING: _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

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2 830	Continued From page 12 identified a Brief Interview of Mental Status (BIMS) score of 14 (intact cognition), extensive assistance of two staff with bed mobility/transfers, at risk for PU and the presence of a lesion on the foot. The CAA dated 8/4/16, included: no pressure ulcers, a scab to hammer toe and bunion and the care plan indicated a turn/repositioning schedule every 2 hours and monitor skin. Review of the shower day worksheet audits for R24 were as noted: (1) 8/1/16-small area to left bunion, (2) 8/5/16- open left bunion, (3) 8/12/16-bunion pink, sore to left bunion and (4) 8/19/16-open left bunion. The nurse progress notes dated 8/19/16, included: open area to left bunion despite padding with foam dressing; red round with well-defined edges; no pressure noted from shoes; no infection symptoms; and foam dressing replaced with skin prep to wound edges. A "get acquainted visit" physician note dated 8/10/16, did not identify the presence of a bunion nor any open area. A fax sent to the physician dated 8/19/16, at 4:38 p.m. identified: small open area to left bunion despite adding foam padding to area; measured 0.5 cm by 0.5 cm.; and continue foam dressing. The fax was noted, signed by the physician and faxed back to the facility on 8/22/16, at 1:52 p.m. The 8/19/16, wound observation tool identified the open area as: measurement-0.5 cm by 0.5 cm moist area with 100% granulation tissue. The treatment was to continue adhesive foam dressing every 3 days. A nurses progress note dated 8/25/16, identified: foam dressing was replaced to left bunion; an	2 830		

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2 830	Continued From page 13	2 830		

additional sore was noted to the left bunion; and a total of two open areas were noted to bunion. No measurements were documented. The wound observation tool dated 8/25/16, identified: area worsening, measured 0.5 cm by 0.5 cm, and moist with 100% granulation.

A nurses note dated 8/31/16, indicated R24 had an appointment scheduled with the podiatrist on 8/31/16, but the appointment was canceled and rescheduled for 9/8/16 due to R24 not feeling well. The wound observation tool dated 9/1/16, identified the area as worsening with 50% granulation tissue and 50% slough tissue and measuring 0.8 cm by 1.3 cm. The current treatment plan was to continue foam dressing changes 2 times per week. The evaluation identified worsened sore. Although the wound was noted to worsen according to the documentation dated 8/25/16 and 9/1/16, no revisions and/or reassessments occurred to ensure healing occurred.

During interview on 9/21/16, at 8:03 a.m. R24 stated the bunion was not sore initially but the more she had therapy the more it started to hurt. She stated, "you are working your shoe all the time and it hurt." R24 received physical therapy until 9/9/16. Documentation was lacking to indicate the plan of care was revised to address the offloading of the foot to remove pressure from R24's regular shoe.

Review of a podiatry visit note dated 9/8/16, identified a full thickness ulceration over the left foot bunion, approximately 1 cm in diameter. The ulceration was debrided and a dressing and surgical shoe utilized. New orders were written for Bacitracin ointment, gauze and kling wrap to foot, surgical shoe (open toe shoe) to offload

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2 830	Continued From page 14	2 830		

ulcer and return in 4 weeks. The wound evaluation tool dated 9/9/16, identified: 75 % granulation tissue, 25 % slough tissue, measurement-0.8 cm by 1.2 cm and treatment of Bacitracin, gauze and kerlex daily change.

A physician visit note dated 9/14/16, identified the ulceration on the bunion as measuring 0.6 cm by 0.6 cm and pink around the edge. The wound observation tool dated 9/16/16, identified: area unchanged, 10 % granulation tissue and 90 % slough tissue and measurements-0.9 cm by 0.9 cm and 0.1 cm depth. Current treatment identified as Bacitracin and gauze wrap daily.

A nursing progress note dated 9/17/16, at 2:34 p.m. identified the area on R24's left foot ulcer as being red, warm to touch , macerated/non-blanch-able with R24 expressing pain to area with palpation. Nursing progress noted dated 9/17/16, at 9:50 a.m. identified increased drainage noted to left foot at bunion site. The dressing was saturated with drainage with soaked through R24's socks. The site was identified at red and warm to touch with purulent drainage.

A nursing progress note dated 9/19/16, identified that R24 was receiving the antibiotic medication Cipro for a possible urinary tract infection (a urine culture was pending, but no growth after one day). A fax from the physician dated 9/19/16, indicated to continue Cipro which would cover the foot infection and a culture of the open area on bunion was ordered.

Documentation on R24's wound evaluation tool dated 9/21/16, identified: area worsening, 100 % slough tissue, 0.7 cm by 0.8 cm by 0.9 cm depth, infection suspected and purulent drainage

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2 830	Continued From page 15 present. Treatment: Bacitracin, Adaptic, gauze and kerlex, started on Cipro 500 mg (antibiotic) twice daily on 9/16/16; bunion became inflamed 9/17/16 and culture was obtained on 9/19/16. During interview on 9/22/16, at 12:21 p.m. registered nurse (RN)-D verified the left bunion of R24 had an open area when admitted (7/28/16) and the physician was notified of the open area by fax on 8/19/16. The physician responded to the fax on 8/22/16 with "noted". RN-D verified the physician should have been notified of the open area when identified on admission. She stated "we just covered it with a foam dressing; [R24's] shoes didn't seem tight like they were adding pressure or anything." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate all licensed staff on the need to monitor non-pressure skin conditions and/or non-pressure skin conditions present on residents upon admission to the facility. The director of nursing could develop an audit to monitor staff compliance with the policy. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home	2 900		10/28/16

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2 900	Continued From page 16 without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to provide the appropriate treatment to prevent further deterioration of pressure ulcers for 1 of 1 (R18) resident reviewed with facility acquired pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers, no pressure ulcer (PU) identified, is turned a minimum of every 6 hours and tolerates this per assessment. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine of R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left	2 900	Corrected.	

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2 900	Continued From page 17	2 900		

open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing applied to lower spine. Three bony prominence's were identified with skin breakdown: (#1) upper wound has pinkness that is resolving, (#2) middle wound has 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during Sitz baths; Sitz baths were discontinued 8/15/16.

During observation on 9/20/16, at 2:07 p.m. R18 was lying supine (on back) in bed. At 2:37 p.m. R18 was resting in bed facing the window. R18 had a pillow positioned behind her back and a wedge under legs. At 3:31 p.m. she remained in the same position but lying more on her back than side.

On 9/21/16, at 7:00 a.m. R18 was observed in the bathroom seated on the toilet with EZ stand hooked up. R18's back was resting/pressing against the toilet seat cover. R18's spine was curved and kyphotic. At approximately 7:15 a.m. R18 was assisted from the toilet and transferred into the wheel chair which had a thin piece of lambs wool over the back. At 9:30 a.m. R18 was observed seated in a recliner. At 10:20 a.m. registered nurse (RN) A was observed doing a wound treatment to R18's spine. The top wound (#1) was reddened and did not appear open, the middle area (#2) had an open area and the bottom (#3) open area was covered with slough. R18 had a rolled bath blanket behind her lower back. RN-A stated this was to relieve pressure from her back and had just (9/20/16) been implemented. At 1:26 p.m. R18 was observed on the toilet hooked up to EZ stand. R18's back/spine was again pressing up against the toilet seat cover until she was assisted back to

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2 900	Continued From page 18 bed at approximately 1:36 p.m. There was no padding/protection between the resident and the hard surface. On 9/22/16, at 12:43 p.m. R18 was seated on the toilet, hooked up to EZ stand. R18's kyphotic appearing back/spine remained pressed against the toilet seat cover. R18 was taken off the toilet and put to bed at approximately 12:55 p.m. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound (#1) as a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower spine wound (#3) as an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open areas present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. No reassessments were conducted and/or interventions revised after noted skin breakdown. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spine. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine.	2 900		

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2 900	Continued From page 19 The wound observation tool for R18 dated 9/9/16, identified the spine wound located on the lower area (#3) as being a Stage III PU (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Documentation indicated the physician was notified of the identified pressure ulcers on 9/6/16. The wound observation tool dated 9/21/16, identified the upper wound on the spine (#1) as being a Stage II PU and the lower spine (#3) wound as a Stage III PU. During interview on 9/22/16, at 12:43 p.m. nursing assistant (NA) A verified R18's back [bony prominence] does press against the toilet seat while seated on the toilet. She stated she routinely sits for 5-10 minutes at a time in this position. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)- D stated she thought the sores started from R18 sitting on the toilet for longer periods of time due to having sitz baths. She stated the sitz baths were discontinued on 8/15/16, but she could not identify when the sitz baths were started. She stated she thought they had been doing them maybe 2 weeks before they discontinued them. She verified the pressure areas were identified on 8/16/16, and stated she put a foam dressing on right away. She stated the lambs wool placed on the wheel chair was implemented this week and the rolled bath blanket behind back in recliner had been implemented on 9/19/16. RN-D further stated I didn't really think about them being from pressure and also confirmed that all three areas on the	2 900		

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2 900	Continued From page 20 spine were open again. RN-D stated the top one (#1) was healed on Friday (9/16/16) but had re-opened. RN-D verified R18 still had pressure to the open areas/bony prominence when toileted and resting against the seat due to her kyphosis. She verified R18 would have pressure on her back from the toileting and sitting. She stated R18 had not been reassessed for positioning since the PU developed and repositioning every 6 hours would not be adequate as defined in the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZN4M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00798

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245358**

2. STATE VENDOR OR MEDICAID NO. (L2) **764975000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HILLTOP CARE CENTER**
(L4) **410 LUELLA STREET**
(L5) **WATKINS, MN** (L6) **55389**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **05/01/2002**

6. DATE OF SURVEY **09/22/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 10/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/27/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **10/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
October 7, 2016

Mr. Fred Struzyk, Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

RE: Project Number S5358025

Dear Mr. Struzyk:

On September 22, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion.Therefore, if your facility has not achieved substantial compliance by November 1, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 22, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		10/28/16

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

Electronically Signed | 10/21/2016

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to immediately notify the physician of the open wounds located on the bony prominence's of the spine 1 of 1 resident (R18) reviewed who developed pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers (PU) and no pressure ulcer present. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine for R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left open to the air. A progress noted dated 8/22/16, identified	F 157	Resident 18's physician was notified on 9/6/16 regarding pressure ulcers. Physician is updated on wound progress on rounds and if wound shows no progress in 2 weeks or if wound deteriorates. Staff was provided education on wounds and to notify the physician upon discovery of a wound. DON or designee will audit residents with pressure ulcers to ensure the physician is notified upon discovery and as needed. The DON will present to the Quality Assurance Committee the audit findings on physician notification and the Quality Assurance Committee will determine continuing periodic auditing.	

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F 157	Continued From page 2 adhesive foam dressing was applied to the lower spine; three bony prominence's with skin breakdown were: (#1) upper wound on spine has pinkness that is resolving, (#2) middle wound located on the spine measured 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during sitz baths; Sitz baths were discontinued 8/15/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician was notified of the identified PU on 9/6/16 even though it was first identified on 8/16/16 and documentation dated 8/22/16, indicated the wound located on the upper part of the spine was due to deep tissue injury and the lower wound was documented as unstageable PU. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open area present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to	F 157		

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F 157	Continued From page 3 spine. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spinal column. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)-D stated she thought the sores started as a result of R18 sitting on the toilet for longer periods of time due to sitz baths. RN-D confirmed the sitz baths were discontinued on 8/15/16; however, the PU's were first identified on 8/16/16, and the physician was not notified until 9/6/16. RN-D verified the physician should have been notified sooner.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and monitor significant bruising for 3 of 3 residents (R15, R41, R60) reviewed for non- pressure related skin problems and failed to assess, revise and	F 309	Resident's 15 and 41 have daily monitoring of bruises documented in their electronic medical record. Resident 60 discharged. Resident 24 has daily monitoring of bunion wound in electronic	10/28/16

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F 309	Continued From page 4 implement timely interventions to promote healing for 1 of 1 resident (R24) reviewed who had a bunion wound. Findings include: R15 Current diagnosis listed on the care plan dated 7/12/16, for R15 included chronic obstructive pulmonary disease (COPD), hypothyroid, hypertension, dementia, obesity and atrial fibrillation. The Minimum Data Set (MDS) assessment dated 8/10/16, indicated R15's Brief Interview of Mental Status (BIMS) score was 15, indicating no cognitive impairment. On 9/19/16, at 3:53 p.m. R15 was observed to have large bruises on both forearms, hands and knees. R15 had arm protectors donned and indicated she has a skin tear located on the left elbow. It was noted that a dressing covered a part of the wound. When interviewed at this time, R15 explained, "those are all from the hospital, they just roll you over, they don't care." During further observation of R15's arms, the following was noted: The left arm had a Vaseline dressing over a skin tear located at the left elbow area, which was wrapped with a soft gauze. The arm had bruising which appeared dark maroon to dark purple in color. This bruising extended around the circumference of the arm from the fingers extending to the area above the elbow, 4.5 inches. The backside (posterior) of the upper arm had a rectangle shaped bruise which measures 3.5 x 5 inches. Bruising was noted on the tops of both hands, covering the entire surface. The right arm had bruising which started at the top of the hand, circumferences the arm at the wrist and extended to above the elbow approx. 2 inches.	F 309	medical record. Staff was provided education on daily monitoring of bruises and non-pressure related wounds and when to notify physician. DON or designee will audit residents with bruises and non-pressure related wounds weekly to ensure that daily documentation is completed. The DON will present to the Quality Assurance Committee the audit findings on bruise and non-pressure related wound documentation and the Quality Assurance Committee will determine continuing periodic auditing.	

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F 309	Continued From page 5	F 309		

The outer forearm revealed an uncovered open wound, measuring 1.5 x 2 inches. The wound bed appeared to be open and a ½ inch opening with a weepy base was evident through the dermis. The surrounding tissue was very dry and the skin was peeling.

Review of the current care plan dated 7/12/16, identified R15 at risk for skin breakdown due to decreased mobility and incontinence; ulcer present to right forearm from a hematoma and skin tear to the left elbow. Interventions indicated R15 bruises easily, had been on Coumadin (blood thinner), only on aspirin now and to apply a protective sleeve daily.

Documentation in the record revealed R15 was hospitalized from 9/6/16-9/16/16 for treatment of sepsis and pneumonia. The hospital transfer form dated 9/16/16, identified that R15 had large dark bruising to the body; involving the arms, hands, knees, sides of breasts and abdomen. Documentation indicated R15 had been on Coumadin and aspirin prior to hospitalization but was discharged on aspirin only.

Review of the admission assessment dated 9/16/16, also identified that R15 had extensive bruising to both upper extremities, faded to right knee, bruising to dorsal hands and a large skin tear to the left elbow which was L shaped, measuring 7 centimeters and 3 centimeters in length. Steri-strips and a secondary dressing were applied.

When interviewed on 9/22/16, at 12:03 p.m. registered nurse (RN)-A stated R15 returned from the hospital stay with bruising to bilateral (both) upper extremities, fading bruises on the right

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F 309	Continued From page 6	F 309		

knee and bruising to dorsal (posterior) hands. She confirmed documentation was not available to review related to any ongoing assessment and/or status of the extensive bruising.

R41
R41 had diagnoses according to the face sheet dated 9/22/16, which included dementia with Lewy body disease (2/8/16) and history of multiple falls. R41 returned from the hospital on 9/16/16 with bruising noted to bilateral upper and lower extremities; bruising faded to right knee, bruising to dorsal hands, purplish color from shins to toes.

On 9/20/16, at 10:48 a.m. R41 was observed to have bruises on both elbows, top of both lower arms, both wrists and both hands. These bruises were dark purplish to maroon in color and varied in size. Interview with R41 at this time indicated he was unsure of when or how he obtained these bruises. The identified bruises varied in size on both arms, wrists and hands. The top of the right hand revealed one bruise 1.5 inches between the second and third finger. On the top surface of the right hand there was another 2 inch bruise. The top of the wrist had a 3 inch bruise, (involving the sides of the wrist). The forearm had 3 more bruises: 2 x 3 inches, 1 x 1 inch and 2 x 3 inches. Located above the elbow was a 3 x 4 inch dark purple bruise. On top of the left hand were two 1 inch bruises and the left forearm had 2 bruises measuring 3.5 x 4 inches.

Review of the current care plan 9/4/16, identified R41 had experienced 12 falls in the last 3 months. The care plan intervention identified the spouse brought in long sleeve shirts for R41 to wear to reduce the risk of skin tears with falls.

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F 309	Continued From page 7 The care plan also revealed that arm protector sleeves have been attempted but R41 kept removing them so they were discontinued. When interviewed on 9/22/16, at 12:23 p.m. RN-B indicated she was aware of R41's bruises on the arms, wrists and hands. RN-B further indicated R41 always has some kind of bruising on his arms and confirmed these bruises had not been monitored on the treatment sheets nor in any other format. RN-B confirmed she had never seen any monitoring for bruises while working at the facility. Interview with RN-D on 9/21/16, at 12:27 p.m. confirmed R41 frequently has bruises on his arms and hands from falls. She further indicated that staff have attempted in the past to don sleeve protectors, but R41 removed them. RN-D confirmed staff had not had a system for monitoring any of R41's bruises for healing and/or deterioration. R60 It was observed on 9/19/16, at 11:49 a.m. that R60 had significant bruising on his arms. R60's hands and arms had dark purple to maroon color bruises. The top of his right hand revealed two 1.5 inch bruises. The forearm had 4 x 4 inch bruises which involved the circumference of the arm. Located above the elbow was a 3 x 4 inch bruise. The left arm revealed two 1 inch bruises and the forearm had one 3 x 4 inch bruise and two 1.5 inch bruises. The bruises were all dark purple to maroon in color. Interview with R60 at the time indicated he was unsure of how he got them but shared he has a history of easily bruising. The quarterly assessment dated 7/7/16, indicated R60 had a Brief Interview of Mental	F 309		

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F 309	Continued From page 8 Status (BIMS) score of 15, indicating no cognitive impairment. Review of the R60 current care plan dated 7/14/16, identified him as having a potential for skin alteration due to the dying process and end of life and decreased mobility. The care plan revealed diagnosis which included: atrial fibrillation, malignant neoplasm of the lung, anemia due to chemotherapy and chronic kidney disease. Review of the bath audit skin observations for July, August, and September 2016 identified there was no documentation related to the significant bruising evident on R60's arms. During an interview on 9/22/16, at 10:17 a.m. RN-B stated that upon discovery of a new wound, a bruise and/or a skin tear, an alert is created by the nursing assistant in the software system. The alert is electronically sent to the charge nurse which subsequently triggers an assessment, treatment and/or monitoring program. RN-B confirmed that monitoring bruising to identify deterioration and/or healing would be a good idea. During an interview 9/22/16, at 10:10 a.m. RN-D confirmed there was no system to monitor the significant bruising on the arms of R60. RN-D stated that R60 has experienced bruising since admission on 3/16/16. When interviewed on 9/22/16, at 12:12 p.m. the director of Nursing (DON) confirmed there is not a system implemented to monitor skin bruising. DON stated that if there was a change in condition of a wound it would be documented in the progress notes but there was no current	F 309		

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F 309	Continued From page 9 process for daily/weekly skin monitoring. She confirmed there is no policy to address monitoring of non-pressure related wounds or bruises. During a subsequent interview with the DON on 9/22/16, at 1:00 p.m. the DON presented a picture of a monitoring system to be set up in the facility software and indicated she would implement this system for monitoring and assessing resident bruises after staff were educated. Review of the facility skin care policy dated 5/2011, indicates skin problems are identified and treatments instituted promptly. A registered nurse oversees each residents skin care in accordance with the comprehensive assessment/care plan. The facility staff receive education on skin care and standard protocol to assure accurate documentation and timely interventions for skin care or problems. R24 Review of R24's admission assessment dated 7/28/16, identified that R24 had a 0.2 cm by 0.2 cm open area to callused area on left bunion; Scant weeping drainage and bilateral bunion with approximately 1 cm pinkness was present. Foam dressings were placed on both bunion for protection at the time of admission, (7/28/16). The admission MDS assessment dated 8/4/16, identified a Brief Interview of Mental Status (BIMS) score of 14 (intact cognition), extensive assistance of two staff with bed mobility/transfers, at risk for PU and the presence of a lesion on the foot. The CAA dated 8/4/16, included: no pressure ulcers, a scab to hammer toe and bunion and the care plan indicated a turn/repositioning schedule every 2 hours and	F 309		

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	245358	A. BUILDING _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 10 monitor skin. Review of the shower day worksheet audits for R24 were as noted: (1) 8/1/16-small area to left bunion, (2) 8/5/16- open left bunion, (3) 8/12/16-bunion pink, sore to left bunion and (4) 8/19/16-open left bunion. The nurse progress notes dated 8/19/16, included: open area to left bunion despite padding with foam dressing; red round with well-defined edges; no pressure noted from shoes; no infection symptoms; and foam dressing replaced with skin prep to wound edges. A "get acquainted visit" physician note dated 8/10/16, did not identify the presence of a bunion nor any open area. A fax sent to the physician dated 8/19/16, at 4:38 p.m. identified: small open area to left bunion despite adding foam padding to area; measured 0.5 cm by 0.5 cm.; and continue foam dressing. The fax was noted, signed by the physician and faxed back to the facility on 8/22/16, at 1:52 p.m. The 8/19/16, wound observation tool identified the open area as: measurement-0.5 cm by 0.5 cm moist area with 100% granulation tissue. The treatment was to continue adhesive foam dressing every 3 days. A nurses progress note dated 8/25/16, identified: foam dressing was replaced to left bunion; an additional sore was noted to the left bunion; and a total of two open areas were noted to bunion. No measurements were documented. The wound observation tool dated 8/25/16, identified: area worsening, measured 0.5 cm by 0.5 cm, and moist with 100% granulation.	F 309		

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F 309	Continued From page 11	F 309		

A nurses note dated 8/31/16, indicated R24 had an appointment scheduled with the podiatrist on 8/31/16, but the appointment was canceled and rescheduled for 9/8/16 due to R24 not feeling well. The wound observation tool dated 9/1/16, identified the area as worsening with 50% granulation tissue and 50% slough tissue and measuring 0.8 cm by 1.3 cm. The current treatment plan was to continue foam dressing changes 2 times per week. The evaluation identified worsened sore. Although the wound was noted to worsen according to the documentation dated 8/25/16 and 9/1/16, no revisions and/or reassessments occurred to ensure healing occurred.

During interview on 9/21/16, at 8:03 a.m. R24 stated the bunion was not sore initially but the more she had therapy the more it started to hurt. She stated, "you are working your shoe all the time and it hurt." R24 received physical therapy until 9/9/16. Documentation was lacking to indicate the plan of care was revised to address the offloading of the foot to remove pressure from R24's regular shoe.

Review of a podiatry visit note dated 9/8/16, identified a full thickness ulceration over the left foot bunion, approximately 1 cm in diameter. The ulceration was debrided and a dressing and surgical shoe utilized. New orders were written for Bacitracin ointment, gauze and kling wrap to foot, surgical shoe (open toe shoe) to offload ulcer and return in 4 weeks. The wound evaluation tool dated 9/9/16, identified: 75 % granulation tissue, 25 % slough tissue, measurement-0.8 cm by 1.2 cm and treatment of Bacitracin, gauze and kerlex daily change.

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F 309	Continued From page 12	F 309		

A physician visit note dated 9/14/16, identified the ulceration on the bunion as measuring 0.6 cm by 0.6 cm and pink around the edge. The wound observation tool dated 9/16/16, identified: area unchanged, 10 % granulation tissue and 90 % slough tissue and measurements-0.9 cm by 0.9 cm and 0.1 cm depth. Current treatment identified as Bacitracin and gauze wrap daily.

A nursing progress note dated 9/17/16, at 2:34 p.m. identified the area on R24's left foot ulcer as being red, warm to touch , macerated/non-blanch-able with R24 expressing pain to area with palpation. Nursing progress noted dated 9/17/16, at 9:50 a.m. identified increased drainage noted to left foot at bunion site. The dressing was saturated with drainage with soaked through R24's socks. The site was identified at red and warm to touch with purulent drainage.

A nursing progress note dated 9/19/16, identified that R24 was receiving the antibiotic medication Cipro for a possible urinary tract infection (a urine culture was pending, but no growth after one day). A fax from the physician dated 9/19/16, indicated to continue Cipro which would cover the foot infection and a culture of the open area on bunion was ordered.

Documentation on R24's wound evaluation tool dated 9/21/16, identified: area worsening, 100 % slough tissue, 0.7 cm by 0.8 cm by 0.9 cm depth, infection suspected and purulent drainage present. Treatment: Bacitracin, Adaptic, gauze and kerlex, started on Cipro 500 mg (antibiotic) twice daily on 9/16/16; bunion became inflamed 9/17/16 and culture was obtained on 9/19/16.

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F 309	Continued From page 13 During interview on 9/22/16, at 12:21 p.m. registered nurse (RN)-D verified the left bunion of R24 had an open area when admitted (7/28/16) and the physician was notified of the open area by fax on 8/19/16. The physician responded to the fax on 8/22/16 with "noted". RN-D verified the physician should have been notified of the open area when identified on admission. She stated "we just covered it with a foam dressing; [R24's] shoes didn't seem tight like they were adding pressure or anything."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to provide the appropriate treatment to prevent further deterioration of pressure ulcers for 1 of 1 (R18) resident reviewed with facility acquired pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief	F 314	Resident 18 had reassessment of both sitting and lying assessments. Resident 18 had OT evaluation to review positioning and make recommendations. Resident 18's plan of care was updated. Staff was provided education on pressure ulcers and facility policy on treatment of pressure ulcers. DON or designee will audit residents with pressure ulcers weekly to ensure that assessments are completed and facility policy is followed.	10/28/16

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F 314	Continued From page 14 Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers, no pressure ulcer (PU) identified, is turned a minimum of every 6 hours and tolerates this per assessment. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine of R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing applied to lower spine. Three bony prominence's were identified with skin breakdown: (#1) upper wound has pinkness that is resolving, (#2) middle wound has 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during Sitz baths; Sitz baths were discontinued 8/15/16. During observation on 9/20/16, at 2:07 p.m. R18 was lying supine (on back) in bed. At 2:37 p.m. R18 was resting in bed facing the window. R18 had a pillow positioned behind her back and a wedge under legs. At 3:31 p.m. she remained in the same position but lying more on her back than side. On 9/21/16, at 7:00 a.m. R18 was observed in the bathroom seated on the toilet with EZ stand hooked up. R18's back was resting/pressing against the toilet seat cover. R18's spine was	F 314	The DON will present to the Quality Assurance Committee the audit findings on pressure sores and the Quality Assurance Committee will determine continuing periodic auditing.	

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F 314	Continued From page 15	F 314		

curved and kyphotic. At approximately 7:15 a.m. R18 was assisted from the toilet and transferred into the wheel chair which had a thin piece of lambs wool over the back. At 9:30 a.m. R18 was observed seated in a recliner. At 10:20 a.m. registered nurse (RN) A was observed doing a wound treatment to R18's spine. The top wound (#1) was reddened and did not appear open, the middle area (#2) had an open area and the bottom (#3) open area was covered with slough. R18 had a rolled bath blanket behind her lower back. RN-A stated this was to relieve pressure from her back and had just (9/20/16) been implemented. At 1:26 p.m. R18 was observed on the toilet hooked up to EZ stand. R18's back/spine was again pressing up against the toilet seat cover until she was assisted back to bed at approximately 1:36 p.m. There was no padding/protection between the resident and the hard surface.

On 9/22/16, at 12:43 p.m. R18 was seated on the toilet, hooked up to EZ stand. R18's kyphotic appearing back/spine remained pressed against the toilet seat cover. R18 was taken off the toilet and put to bed at approximately 12:55 p.m.

The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound (#1) as a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower spine wound (#3) as an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

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F 314	Continued From page 16	F 314		

Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open areas present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. No reassessments were conducted and/or interventions revised after noted skin breakdown.

A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spine. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine.

The wound observation tool for R18 dated 9/9/16, identified the spine wound located on the lower area (#3) as being a Stage III PU (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Documentation indicated the physician was notified of the identified pressure ulcers on 9/6/16.

The wound observation tool dated 9/21/16, identified the upper wound on the spine (#1) as being a Stage II PU and the lower spine (#3) wound as a Stage III PU.

During interview on 9/22/16, at 12:43 p.m. nursing assistant (NA) A verified R18's back [bony prominence] does press against the toilet seat while seated on the toilet. She stated she routinely sits for 5-10 minutes at a time in this

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F 314	Continued From page 17 position. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)- D stated she thought the sores started from R18 sitting on the toilet for longer periods of time due to having sitz baths. She stated the sitz baths were discontinued on 8/15/16, but she could not identify when the sitz baths were started. She stated she thought they had been doing them maybe 2 weeks before they discontinued them. She verified the pressure areas were identified on 8/16/16, and stated she put a foam dressing on right away. She stated the lambs wool placed on the wheel chair was implemented this week and the rolled bath blanket behind back in recliner had been implemented on 9/19/16. RN-D further stated I didn't really think about them being from pressure and also confirmed that all three areas on the spine were open again. RN-D stated the top one (#1) was healed on Friday (9/16/16) but had re-opened. RN-D verified R18 still had pressure to the open areas/bony prominence when toileted and resting against the seat due to her kyphosis. She verified R18 would have pressure on her back from the toileting and sitting. She stated R18 had not been reassessed for positioning since the PU developed and repositioning every 6 hours would not be adequate as defined in the plan of care.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		10/28/16

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F 329	Continued From page 18 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify the need for laboratory monitoring of a cholesterol lowering medication (simvastatin) for 1 of 5 residents (R34) reviewed for unnecessary medications. Findings include: According to the resident admission record face sheet, R34 was admitted with diagnoses including: heart failure, hyperlipidemia (high cholesterol level) and cardiomegaly. Review of the Physician Order Report dated 8/3/16, directed Simvastatin 40 mg (milligrams) be given at bedtime (used to lower cholesterol	F 329	This plan and response to this finding is written solely to maintain certification in the Medicare and Medicaid programs. These written responses do not constitute an admission of non-compliance nor any agreement with any findings. We have requested an Informal Dispute Resolution. Resident 34 had laboratory values for lipids dated 3/14/16 present in chart. Review of the consultant pharmacist monthly drug review documentation form dated 8/11/16 made no mention of a recommendation to the physician regarding laboratory monitoring, lipids, or cholesterol medication. The consulting pharmacist documentation on 9/15/16	

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F 329	Continued From page 19 levels) and included a order to check fasting lipids annually. Review of most current laboratory values for lipids (cholesterol/fats) was dated 3/15/15, (more than 15 months). Review of the consultant pharmacist's monthly drug review documentation form did indicate a recommendation for annual laboratory lipid tests related to cholesterol and the ongoing use of simvastatin. During interview on 9/22/16, at 12:42 p.m. the director of nursing (DON) confirmed she was unable to provide tests for cholesterol monitoring completed in the last 15 months. Record review revealed that on 8/13/16, the consulting pharmacist confirmed the last documented lipid panel was drawn on 3/15/15. The pharmacist made a recommendations to the physician related to laboratory monitoring with use of a cholesterol lowering medication or rationale why not to be completed.	F 329	present in resident's chart indicates lipids last checked 3/16.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 21, 2016. At the time of this survey, Hilltop Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/11/2016

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Hilltop Care Center was constructed in 1978, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 48 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		9/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245358	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	**410 LUELLA STREET** **WATKINS, MN 55389**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 2 9.7.5 This STANDARD is not met as evidenced by: FIRE SAFETY Based on observation and staff interview, the facility failed to maintain proper sprinkler coverage in accordance 19.7.6, 4.6.12, NFPA 25, 9.7.5.This deficient practice could affect 5 resident in the event of a fire. Finding include: On facility tour between the hours of 8:30 am and 11:30 am on 09/21/2016, it was observed that a sprinkler head was concealed above the ceiling tile in the Activity Office not in accordance with 19.7.6. This deficient practice was verified by the Administrator.	K 062	Service Technicians from Summit Fire Companies lowered the sprinkler head beneath the ceiling tile on 9/22/2016. Completion date: 09/22/2016 Location of Sprinklers was added to our punch list for remodeling. The Director of Maintenance is responsible to verify the punch list is done upon the completion of a remodeling project	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
October 7, 2016

Mr. Fred Struzyk, Administrator
Hilltop Care Center
410 Luella Street
Watkins, MN 55389

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5358025

Dear Mr. Struzyk:

The above facility was surveyed on September 19, 2016 through September 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the

Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00798	A. BUILDING: _____ B. WING _____	09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLTOP CARE CENTER	410 LUELLA STREET WATKINS, MN 55389

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On September 19-22, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		10/28/16

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to immediately notify the physician of the open wounds located on the bony prominence's of the spine 1 of 1 residents (R18) reviewed who developed pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers (PU) and no pressure ulcer present. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine for R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing was applied to the lower spine; three bony prominence's with skin breakdown were: (#1) upper wound on spine has pinkness that is resolving, (#2) middle wound located on the spine measured 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound located on the spine has 0.5 cm x 0.8 cm scab.	2 265	Corrected.	

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2 265	Continued From page 4 Wounds occurred with longer period of sitting on toilet during sitz baths; Sitz baths were discontinued 8/15/16. Although documentation indicated the daughter was updated on wounds at this time, no physician notice was evident. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound-(#1) a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower wound (#3) an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Documentation indicated the physician was notified of the identified PU on 9/6/16 even though it was first identified on 8/16/16 and documentation dated 8/22/16, indicated the wound located on the upper part of the spine was due to deep tissue injury and the lower wound was documented as unstageable PU. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open area present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spinal column. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid	2 265		

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2 265	Continued From page 5 in healing the spine. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)-D stated she thought the sores started as a result of R18 sitting on the toilet for longer periods of time due to sitz baths. RN-D confirmed the sitz baths were discontinued on 8/15/16; however, the PU's were first identified on 8/16/16, and the physician was not notified until 9/6/16. RN-D verified the physician should have been notified sooner. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop and monitor policies and procedures to ensure practioners are notified of changes in residents condition accurately. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		10/28/16

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2 830	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess and monitor significant bruising for 3 of 3 residents (R15, R41, R60) reviewed for non- pressure related skin problems and failed to assess, revise and implement timely interventions to promote healing for 1 of 1 resident (R24) reviewed who had a bunion wound. Findings include: R15 Current diagnosis listed on the care plan dated 7/12/16, for R15 included chronic obstructive pulmonary disease (COPD), hypothyroid, hypertension, dementia, obesity and atrial fibrillation. The Minimum Data Set (MDS) assessment dated 8/10/16, indicated R15's Brief Interview of Mental Status (BIMS) score was 15, indicating no cognitive impairment. On 9/19/16, at 3:53 p.m. R15 was observed to have large bruises on both forearms, hands and knees. R15 had arm protectors donned and indicated she has a skin tear located on the left elbow. It was noted that a dressing covered a part of the wound. When interviewed at this time, R15 explained, "those are all from the hospital, they just roll you over, they don't care." During further observation of R15's arms, the following was noted: The left arm had a Vaseline dressing over a skin tear located at the left elbow area, which was wrapped with a soft gauze. The arm had bruising which appeared dark maroon to dark	2 830	Corrected.	

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2 830	Continued From page 7	2 830		

purple in color. This bruising extended around the circumference of the arm from the fingers extending to the area above the elbow, 4.5 inches. The backside (posterior) of the upper arm had a rectangle shaped bruise which measures 3.5 x 5 inches. Bruising was noted on the tops of both hands, covering the entire surface. The right arm had bruising which started at the top of the hand, circumferences the arm at the wrist and extended to above the elbow approx. 2 inches. The outer forearm revealed an uncovered open wound, measuring 1.5 x 2 inches. The wound bed appeared to be open and a ½ inch opening with a weepy base was evident through the dermis. The surrounding tissue was very dry and the skin was peeling.

Review of the current care plan dated 7/12/16, identified R15 at risk for skin breakdown due to decreased mobility and incontinence; ulcer present to right forearm from a hematoma and skin tear to the left elbow. Interventions indicated R15 bruises easily, had been on Coumadin (blood thinner), only on aspirin now and to apply a protective sleeve daily.

Documentation in the record revealed R15 was hospitalized from 9/6/16-9/16/16 for treatment of sepsis and pneumonia. The hospital transfer form dated 9/16/16, identified that R15 had large dark bruising to the body; involving the arms, hands, knees, sides of breasts and abdomen. Documentation indicated R15 had been on Coumadin and aspirin prior to hospitalization but was discharged on aspirin only.

Review of the admission assessment dated 9/16/16, also identified that R15 had extensive bruising to both upper extremities, faded to right knee, bruising to dorsal hands and a large skin

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2 830	Continued From page 8 tear to the left elbow which was L shaped, measuring 7 centimeters and 3 centimeters in length. Steri-strips and a secondary dressing were applied. When interviewed on 9/22/16, at 12:03 p.m. registered nurse (RN)-A stated R15 returned from the hospital stay with bruising to bilateral (both) upper extremities, fading bruises on the right knee and bruising to dorsal (posterior) hands. She confirmed documentation was not available to review related to any ongoing assessment and/or status of the extensive bruising. R41 R41 had diagnoses according to the face sheet dated 9/22/16, which included dementia with Lewy body disease (2/8/16) and history of multiple falls. R41 returned from the hospital on 9/16/16 with bruising noted to bilateral upper and lower extremities; bruising faded to right knee, bruising to dorsal hands, purplish color from shins to toes. On 9/20/16, at 10:48 a.m. R41 was observed to have bruises on both elbows, top of both lower arms, both wrists and both hands. These bruises were dark purplish to maroon in color and varied in size. Interview with R41 at this time indicated he was unsure of when or how he obtained these bruises. The identified bruises varied in size on both arms, wrists and hands. The top of the right hand revealed one bruise 1.5 inches between the second and third finger. On the top surface of the right hand there was another 2 inch bruise. The top of the wrist had a 3 inch bruise, (involving the sides of the wrist). The forearm had 3 more bruises: 2 x 3 inches, 1 x 1 inch and 2 x 3 inches. Located above the elbow was a 3 x 4 inch dark purple bruise. On top of the left hand were two 1	2 830		

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2 830	Continued From page 9 inch bruises and the left forearm had 2 bruises measuring 3.5 x 4 inches. Review of the current care plan 9/4/16, identified R41 had experienced 12 falls in the last 3 months. The care plan intervention identified the spouse brought in long sleeve shirts for R41 to wear to reduce the risk of skin tears with falls. The care plan also revealed that arm protector sleeves have been attempted but R41 kept removing them so they were discontinued. When interviewed on 9/22/16, at 12:23 p.m. RN-B indicated she was aware of R41's bruises on the arms, wrists and hands. RN-B further indicated R41 always has some kind of bruising on his arms and confirmed these bruises had not been monitored on the treatment sheets nor in any other format. RN-B confirmed she had never seen any monitoring for bruises while working at the facility. Interview with RN-D on 9/21/16, at 12:27 p.m. confirmed R41 frequently has bruises on his arms and hands from falls. She further indicated that staff have attempted in the past to don sleeve protectors, but R41 removed them. RN-D confirmed staff had not had a system for monitoring any of R41's bruises for healing and/or deterioration. R60 It was observed on 9/19/16, at 11:49 a.m. that R60 had significant bruising on his arms. R60's hands and arms had dark purple to maroon color bruises. The top of his right hand revealed two 1.5 inch bruises. The forearm had 4 x 4 inch bruises which involved the circumference of the arm. Located above the elbow was a 3 x 4 inch bruise. The left arm revealed two 1 inch bruises	2 830		

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2 830	Continued From page 10 and the forearm had one 3 x 4 inch bruise and two 1.5 inch bruises. The bruises were all dark purple to maroon in color. Interview with R60 at the time indicated he was unsure of how he got them but shared he has a history of easily bruising. The quarterly assessment dated 7/7/16, indicated R60 had a Brief Interview of Mental Status (BIMS) score of 15, indicating no cognitive impairment. Review of the R60 current care plan dated 7/14/16, identified him as having a potential for skin alteration due to the dying process and end of life and decreased mobility. The care plan revealed diagnosis which included: atrial fibrillation, malignant neoplasm of the lung, anemia due to chemotherapy and chronic kidney disease. Review of the bath audit skin observations for July, August, and September 2016 identified there was no documentation related to the significant bruising evident on R60's arms. During an interview on 9/22/16, at 10:17 a.m. RN-B stated that upon discovery of a new wound, a bruise and/or a skin tear, an alert is created by the nursing assistant in the software system. The alert is electronically sent to the charge nurse which subsequently triggers an assessment, treatment and/or monitoring program. RN-B confirmed that monitoring bruising to identify deterioration and/or healing would be a good idea. During an interview 9/22/16, at 10:10 a.m. RN-D confirmed there was no system to monitor the significant bruising on the arms of R60. RN-D stated that R60 has experienced bruising since admission on 3/16/16.	2 830		

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2 830	Continued From page 11 When interviewed on 9/22/16, at 12:12 p.m. the director of Nursing (DON) confirmed there is not a system implemented to monitor skin bruising. DON stated that if there was a change in condition of a wound it would be documented in the progress notes but there was no current process for daily/weekly skin monitoring. She confirmed there is no policy to address monitoring of non-pressure related wounds or bruises. During a subsequent interview with the DON on 9/22/16, at 1:00 p.m. the DON presented a picture of a monitoring system to be set up in the facility software and indicated she would implement this system for monitoring and assessing resident bruises after staff were educated. Review of the facility skin care policy dated 5/2011, indicates skin problems are identified and treatments instituted promptly. A registered nurse oversees each residents skin care in accordance with the comprehensive assessment/care plan. The facility staff receive education on skin care and standard protocol to assure accurate documentation and timely interventions for skin care or problems. R24 Review of R24's admission assessment dated 7/28/16, identified that R24 had a 0.2 cm by 0.2 cm open area to callused area on left bunion; Scant weeping drainage and bilateral bunion with approximately 1 cm pinkness was present. Foam dressings were placed on both bunion for protection at the time of admission, (7/28/16). The admission MDS assessment dated 8/4/16, identified a Brief Interview of Mental Status (BIMS) score of 14 (intact cognition), extensive assistance of two staff with bed mobility/transfers,	2 830		

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2 830	Continued From page 12 at risk for PU and the presence of a lesion on the foot. The CAA dated 8/4/16, included: no pressure ulcers, a scab to hammer toe and bunion and the care plan indicated a turn/repositioning schedule every 2 hours and monitor skin. Review of the shower day worksheet audits for R24 were as noted: (1) 8/1/16-small area to left bunion, (2) 8/5/16- open left bunion, (3) 8/12/16-bunion pink, sore to left bunion and (4) 8/19/16-open left bunion. The nurse progress notes dated 8/19/16, included: open area to left bunion despite padding with foam dressing; red round with well-defined edges; no pressure noted from shoes; no infection symptoms; and foam dressing replaced with skin prep to wound edges. A "get acquainted visit" physician note dated 8/10/16, did not identify the presence of a bunion nor any open area. A fax sent to the physician dated 8/19/16, at 4:38 p.m. identified: small open area to left bunion despite adding foam padding to area; measured 0.5 cm by 0.5 cm.; and continue foam dressing. The fax was noted, signed by the physician and faxed back to the facility on 8/22/16, at 1:52 p.m. The 8/19/16, wound observation tool identified the open area as: measurement-0.5 cm by 0.5 cm moist area with 100% granulation tissue. The treatment was to continue adhesive foam dressing every 3 days. A nurses progress note dated 8/25/16, identified: foam dressing was replaced to left bunion; an additional sore was noted to the left bunion; and a total of two open areas were noted to bunion. No measurements were documented. The wound	2 830		

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2 830	Continued From page 13 observation tool dated 8/25/16, identified: area worsening, measured 0.5 cm by 0.5 cm, and moist with 100% granulation. A nurses note dated 8/31/16, indicated R24 had an appointment scheduled with the podiatrist on 8/31/16, but the appointment was canceled and rescheduled for 9/8/16 due to R24 not feeling well. The wound observation tool dated 9/1/16, identified the area as worsening with 50% granulation tissue and 50% slough tissue and measuring 0.8 cm by 1.3 cm. The current treatment plan was to continue foam dressing changes 2 times per week. The evaluation identified worsened sore. Although the wound was noted to worsen according to the documentation dated 8/25/16 and 9/1/16, no revisions and/or reassessments occurred to ensure healing occurred. During interview on 9/21/16, at 8:03 a.m. R24 stated the bunion was not sore initially but the more she had therapy the more it started to hurt. She stated, "you are working your shoe all the time and it hurt." R24 received physical therapy until 9/9/16. Documentation was lacking to indicate the plan of care was revised to address the offloading of the foot to remove pressure from R24's regular shoe. Review of a podiatry visit note dated 9/8/16, identified a full thickness ulceration over the left foot bunion, approximately 1 cm in diameter. The ulceration was debrided and a dressing and surgical shoe utilized. New orders were written for Bacitracin ointment, gauze and kling wrap to foot, surgical shoe (open toe shoe) to offload ulcer and return in 4 weeks. The wound evaluation tool dated 9/9/16, identified: 75 % granulation tissue, 25 % slough tissue,	2 830		

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2 830	Continued From page 14	2 830		

measurement-0.8 cm by 1.2 cm and treatment of Bacitracin, gauze and kerlex daily change.

A physician visit note dated 9/14/16, identified the ulceration on the bunion as measuring 0.6 cm by 0.6 cm and pink around the edge. The wound observation tool dated 9/16/16, identified: area unchanged, 10 % granulation tissue and 90 % slough tissue and measurements-0.9 cm by 0.9 cm and 0.1 cm depth. Current treatment identified as Bacitracin and gauze wrap daily.

A nursing progress note dated 9/17/16, at 2:34 p.m. identified the area on R24's left foot ulcer as being red, warm to touch , macerated/non-blanch-able with R24 expressing pain to area with palpation. Nursing progress noted dated 9/17/16, at 9:50 a.m. identified increased drainage noted to left foot at bunion site. The dressing was saturated with drainage with soaked through R24's socks. The site was identified at red and warm to touch with purulent drainage.

A nursing progress note dated 9/19/16, identified that R24 was receiving the antibiotic medication Cipro for a possible urinary tract infection (a urine culture was pending, but no growth after one day). A fax from the physician dated 9/19/16, indicated to continue Cipro which would cover the foot infection and a culture of the open area on bunion was ordered.

Documentation on R24's wound evaluation tool dated 9/21/16, identified: area worsening, 100 % slough tissue, 0.7 cm by 0.8 cm by 0.9 cm depth, infection suspected and purulent drainage present. Treatment: Bacitracin, Adaptic, gauze and kerlex, started on Cipro 500 mg (antibiotic) twice daily on 9/16/16; bunion became inflamed

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2 830	Continued From page 15 9/17/16 and culture was obtained on 9/19/16. During interview on 9/22/16, at 12:21 p.m. registered nurse (RN)-D verified the left bunion of R24 had an open area when admitted (7/28/16) and the physician was notified of the open area by fax on 8/19/16. The physician responded to the fax on 8/22/16 with "noted". RN-D verified the physician should have been notified of the open area when identified on admission. She stated "we just covered it with a foam dressing; [R24's] shoes didn't seem tight like they were adding pressure or anything." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could educate all licensed staff on the need to monitor non-pressure skin conditions and/or non-pressure skin conditions present on residents upon admission to the facility. The director of nursing could develop an audit to monitor staff compliance with the policy. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		10/28/16

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2 900	Continued From page 16 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to provide the appropriate treatment to prevent further deterioration of pressure ulcers for 1 of 1 (R18) resident reviewed with facility acquired pressure ulcers. Findings include: R18's annual Minimum Data Set (MDS) assessment dated 7/23/16, identified a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment, extensive assistance of 2 staff with transfers/bed mobility and does not walk. The Care Area Assessment (CAA) dated 7/25/16, identified R18 as being at risk for pressure ulcers, no pressure ulcer (PU) identified, is turned a minimum of every 6 hours and tolerates this per assessment. Progress notes dated 8/16/16, identified 3 skin/problem areas located on the spine of R18 and were described as noted: (#1) Top area red and measured 1.5 centimeter (cm) by 2 cm; (#2) middle area open measured 0.8 cm by 0.7 cm and (#3) bottom area scabbed and measured 1.5 cm by 1 cm. The area was cleansed and left open to the air. A progress noted dated 8/22/16, identified adhesive foam dressing applied to lower spine. Three bony prominence's were	2 900	Corrected.	

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2 900	Continued From page 17 identified with skin breakdown: (#1) upper wound has pinkness that is resolving, (#2) middle wound has 0.2 cm x 0.2 cm yellow scab and (#3) the lower wound has 0.5 cm x 0.8 cm scab. Wounds occurred with longer period of sitting on toilet during Sitz baths; Sitz baths were discontinued 8/15/16. During observation on 9/20/16, at 2:07 p.m. R18 was lying supine (on back) in bed. At 2:37 p.m. R18 was resting in bed facing the window. R18 had a pillow positioned behind her back and a wedge under legs. At 3:31 p.m. she remained in the same position but lying more on her back than side. On 9/21/16, at 7:00 a.m. R18 was observed in the bathroom seated on the toilet with EZ stand hooked up. R18's back was resting/pressing against the toilet seat cover. R18's spine was curved and kyphotic. At approximately 7:15 a.m. R18 was assisted from the toilet and transferred into the wheel chair which had a thin piece of lambs wool over the back. At 9:30 a.m. R18 was observed seated in a recliner. At 10:20 a.m. registered nurse (RN) A was observed doing a wound treatment to R18's spine. The top wound (#1) was reddened and did not appear open, the middle area (#2) had an open area and the bottom (#3) open area was covered with slough. R18 had a rolled bath blanket behind her lower back. RN-A stated this was to relieve pressure from her back and had just (9/20/16) been implemented. At 1:26 p.m. R18 was observed on the toilet hooked up to EZ stand. R18's back/spine was again pressing up against the toilet seat cover until she was assisted back to bed at approximately 1:36 p.m. There was no padding/protection between the resident and the hard surface.	2 900		

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2 900	Continued From page 18 On 9/22/16, at 12:43 p.m. R18 was seated on the toilet, hooked up to EZ stand. R18's kyphotic appearing back/spine remained pressed against the toilet seat cover. R18 was taken off the toilet and put to bed at approximately 12:55 p.m. The wound observation tool dated 8/22/16, described the problem areas on the spine of R18 as noted: upper wound (#1) as a suspected deep tissue injury (a purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) and the lower spine wound (#3) as an Unstageable PU (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Review of the care plan revised 8/26/16, identified R18 at risk for skin breakdown and open areas present to bony prominence's to back. Interventions included: air mattress on bed, treatment per nursing order, turn and reposition at least every 6 hours when sitting and every 2 hour repositioning at night due to skin breakdown to spine. No reassessments were conducted and/or interventions revised after noted skin breakdown. A review of the nursing home rounds note dated 9/6/16, identified 2 closed areas and one open area of skin breakdown on R18's spine. R18 was identified as quite resistant to being repositioned during the night; however, nursing staff encouraged her to allow repositioning to aid in healing the spine. The wound observation tool for R18 dated 9/9/16, identified the spine wound located on the lower area (#3) as being a Stage III PU (Full thickness	2 900		

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2 900	Continued From page 19 tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling). Documentation indicated the physician was notified of the identified pressure ulcers on 9/6/16. The wound observation tool dated 9/21/16, identified the upper wound on the spine (#1) as being a Stage II PU and the lower spine (#3) wound as a Stage III PU. During interview on 9/22/16, at 12:43 p.m. nursing assistant (NA) A verified R18's back [bony prominence] does press against the toilet seat while seated on the toilet. She stated she routinely sits for 5-10 minutes at a time in this position. During interview on 9/22/16, at 11:46 a.m. registered nurse (RN)- D stated she thought the sores started from R18 sitting on the toilet for longer periods of time due to having sitz baths. She stated the sitz baths were discontinued on 8/15/16, but she could not identify when the sitz baths were started. She stated she thought they had been doing them maybe 2 weeks before they discontinued them. She verified the pressure areas were identified on 8/16/16, and stated she put a foam dressing on right away. She stated the lambs wool placed on the wheel chair was implemented this week and the rolled bath blanket behind back in recliner had been implemented on 9/19/16. RN-D further stated I didn't really think about them being from pressure and also confirmed that all three areas on the spine were open again. RN-D stated the top one (#1) was healed on Friday (9/16/16) but had re-opened. RN-D verified R18 still had pressure	2 900		

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2 900	Continued From page 20 to the open areas/bony prominence when toileted and resting against the seat due to her kyphosis. She verified R18 would have pressure on her back from the toileting and sitting. She stated R18 had not been reassessed for positioning since the PU developed and repositioning every 6 hours would not be adequate as defined in the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the	21540		10/28/16

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21540	Continued From page 21 medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to identify the need for laboratory monitoring of a cholesterol lowering medication (simvastatin) for 1 of 5 residents (R34) reviewed for unnecessary medications. Findings include: According to the resident admission record face sheet, R34 was admitted with diagnoses including: heart failure, hyperlipidemia (high cholesterol level) and cardiomegaly. Review of the Physician Order Report dated 8/3/16, directed Simvastatin 40 mg (milligrams) be given at bedtime (used to lower cholesterol levels) and included a order to check fasting lipids annually. Review of most current laboratory values for lipids (cholesterol/fats) was dated 3/15/15, (more than 15 months). Review of the consultant pharmacist's monthly drug review documentation form did indicate a recommendation for annual laboratory lipid tests related to cholesterol and the ongoing use of simvastatin.	21540	Corrected.	

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21540	Continued From page 22 During interview on 9/22/16, at 12:42 p.m. the director of nursing (DON) confirmed she was unable to provide tests for cholesterol monitoring completed in the last 15 months. Record review revealed that on 8/13/16, the consulting pharmacist confirmed the last documented lipid panel was drawn on 3/15/15. The pharmacist made a recommendations to the physician related to laboratory monitoring with use of a cholesterol lowering medication or rationale why not to be completed. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of proper monitoring of medications. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		