Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

May 12, 2021

Administrator
Firstat Nursing Services
2395 Ariel Street North
Maplewood, MN 55109

RE: Event ID: IV2512

Dear Administrator:

On May 6, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance with federal regulations.

Feel free to contact me with any questions related to this letter.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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April 7, 2021

Administrator
Firstat Nursing Services
2395 Ariel Street North
Maplewood, MN 55109

RE: Event ID: IV2511

Dear Administrator:

An extended survey was completed at your agency on March 15, 2021 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey it was determined that the following Condition(s) of Participation were found not met:

G0570 -- 484.60 -- Care Planning, Coordination, Quality Of Care

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the

deficient practice does not recur;

- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to $10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.

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

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR **484.80(f)(3)**, prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

(A) Out of compliance with requirements of 42 CFR **484.80(f)(3);**

(B) To permit an individual that does not meet the definition of "home health aide" as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);

(C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);

(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;

(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA;

(F) Has had all or part of its Medicare payments suspended; or

(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--

(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients; or
(5) Was closed or had its residents transferred by the State.

Therefore, Firstat Nursing Services is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning March 15, 2021.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction 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:

Home Health Agency 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 a PoC for the cited deficiencies.

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

If you have any questions on this matter, please do not hesitate to call.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248087	A. BUILDING ______ B. WING ______	C 03/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRSTAT NURSING SERVICES	**2395 ARIEL STREET NORTH MAPLEWOOD, MN 55109**

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G 000	INITIAL COMMENTS An abbreviated survey was conducted at your agency on 3/15/2021. Firststat Nursing Services was found NOT to be in compliance with requirements at 42 CFR Part 484, requirements for Home Health Agencies. The following complaint was substantiated H8087009C (MN00070657) with deficiencies cited at G570, G590 and G710. In addition, the Conditions of Participation Care Planning, Coordination and Quality of Care §484.60 at G570, was found NOT met. As a result an extended survey was completed. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Federal Law as specified in 42 CFR 484.80 (f)(3), prohibits any home health agency to offer and/or conduct home health aide training and/or competency testing which, within the previous two years has been subjected to an extended (or partially extended) survey as a result of having been found to have a Federal Condition of Participation not met at the extended survey.	G 000	G570: Care planning, coordination of services and quality of care G570: Promptly alert the physician to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Plan of Correction: •Regarding the LPN: Director of Nursing had a phone and then in-person meeting with BT LPN March 12, and 15 2021. Initial discipline included a verbal and written warning, employee subject to termination. DON provided verbal education with BT-to fully and thoroughly review emails sent by RN Case Manager on every new patient, and review of the referral docs, prior to seeing any new patient for wound care. Additionally, if BT has questions, she is to seek answers well before her scheduled visits for new wound care patients. If there are new orders for wound patients (updated/changed), she is to ensure she has reviewed such orders prior to her scheduled visit. Immediate action taken was to remove BT from all wound vacuum patient visits. Subsequently, we also have removed BT from all wound care visits until the assigned extra education can be completed, wound documentation training completed, and a competency testing review completed. BT will be supervised onsite the first time BT does any wound care post 4/12/2021. • BT again met with Director of Nursing subsequently on April 13, 2021 and was assigned additional education. BT will be reviewing 2-4 webinars/trainings from WOCN.ORG (Wound, Ostomy and Continence Nurses Society website) and/or NPIAP.com (National Pressure Ulcer Advisory Panel website) as well as choosing one article from the Wound Care Management magazine and will be writing a short summary for each one, explaining what she learned from each of them. BT will be attending the nursing wound care documentation training to be held 4/15/2021. All of BT's visits will be audited for a period of 90 days commencing with visits of 4/15/2021. Following this, we will review/audit 5-10 visits per month once each quarter for a period of one year. •Coordination: We have developed a specific policy for Care Coordination for notifying providers when changes occur to meet the patient's needs and involve family, caregivers, the patient, the primary care provider and other health care providers in care coordination. All service providers involved in the care of a patient, including contracted health care professionals or other agencies, will be engaged in an effective interchange, reporting, and coordination of care regarding the patient. Services are integrated to assure that patient needs and factors affecting patient safety and treatment effectiveness are coordinated among all health care providers serving the patient. All such coordination of care will be documented in the patient record.	
G 570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and	G 570	Wound Care Policy: We have developed a wound care policy that addresses the Plan of Care, assessments, documentation, coordination and education. Completed 4/11/21, in place effective 4/16/2021. •All patients receiving wound care will have a weekly Skilled Nurse Visit by RN to inspect wound, document and measure. •Competency evaluations will be conducted for all clinicians related to wound care/wound vacuum prior to performing wound care independently. Effective 4/15/21; to be completed for current staff by 5/1/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Koester
TITLE: Director of Nursing
(X6) DATE: April 15, 2021

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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G 570 Continued From page 1

social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice.

This CONDITION is not met as evidenced by:
Based on interview and document review, the agency was found not to be in compliance with the Condition of Participation at 484.60, Care Planning, Coordination, Quality of Care. The agency failed to notify the provider of potential signs and symptoms of infection and change in condition of a wound, including odor, for 1 of 3 patients (P1) reviewed for wound care. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of care.

Findings include:

Refer to G590: Based on interview and document review the agency failed to notify the provider of potential signs and symptoms of infection and change in condition of a wound, including odor, for 1 of 3 patients (P1) reviewed for wound care.

G 570 — Provider's Plan of Correction:

G570 continued

•All patients receiving wound care will have a weekly SNV by RN for all patients receiving wound care.
Effective 4/19/21

•Competency evaluations will be conducted for all clinicians related to wound care/wound vacuum prior to performing wound care independently. Effective 4/15/21; to be completed for current staff prior to 5/1/21

•Education: All clinicians will be educated regarding the new policy, including the importance of reviewing the Plan of Care, wound assessments, wound care,
documentation and coordination/notifying provider of any changes. Completed 4/15/2021.

•Audits: 100% of visit notes for patients currently receiving wound care beginning 4/15/2021 will be audited
to verify that staff are documenting complete assessments, wound care, education with patients and coordination with providers for a period of three months.. Thereafter, quarterly clinical record
audits of clients receiving wound care will be conducted for the following year.

•100% of visit notes for patients receiving wound care will be audited for 90 days effective April 15, 2021. The frequency of said audits will be every 7-10 days, until July 13, 2021. Also, all of BT's visits will be audited every 7-10 days for the 90 days, ending July 13, 2021. We will then begin quarterly reviews of all visits, auditing 5-10 visits of each nurse monthly, and to include all types of visits. — completion 4/27/2021

•The corrective actions which will be accomplished for those patients found to have been affected by the deficient practice include additional wound care documentation training (completed 4/15/2021). Unfortunately, we are not able to specifically provide specific corrective actions for LJ as she discharged immediately after the deficiency became known to writer (Koester).

•However, for JP and TM, and other wound care patients, we will improve upon and continue to coordinate with the wound clinic to assure that the wound care being provided is effective, discuss the wound care plan with the patients to be sure that they understand it and understand 1) what symptoms should be reported, 2) to whom they should be reported, and 3) when they should be reported

We have a new Care Coordination Policy in effect as well as a Wound Care Management Policy effective April 15, 2021

•Prior to her first wound care patient, all the above will be complete, and a RN will complete a competency checklist with BT, LPN. BT will also have a RN Case Manager with her when she is assigned her first wound patient to supervise her ability and documentation during the first wound care visit. We will also be auditing visits (wound and non-wound) for the initial 90 days, and then again quarterly.

•I, Laura Koester, Director of Nursing, am responsible for implementing the POC, and the date by which the corrections (except the quarterly audits post 90-days) will be implemented by April 27, 2021 — 4/27/2021

G 590 Promptly alert relevant physician of changes
CFR(s): 484.60(c)(1)

G 590

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G 590	Continued From page 2 The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is not met as evidenced by: Based on interview and document review the agency failed to notify the provider of potential signs and symptoms of infection and change in condition of a wound, including odor, for 1 of 3 patients (P1) reviewed for wound care. Findings include: P1 was admitted to the agency on 2/12/21, with diagnoses including; infection following a procedure other surgical site, schizoaffective disorder and chronic pain syndrome. P1's plan of care for certification period 2/12/21 to 4/12/21, indicated P1 received skilled nursing three times a week for eight weeks for wound care, and one visit as needed in case the wound vacuum (device that decreases air pressure on wound to help in wound healing) had issues requiring nursing evaluation. The plan of care also indicated the skilled nurse was to report significant changes to the physician, provide negative pressure wound therapy to the stomach, assess and instruct the patient on signs and symptoms of infection and to assess the skin/wound for any signs and symptoms of infection. P1's plan of care for wound care directed the nurse to cleanse/irrigate the wound on the stomach with normal saline, dry with gauze, prepare skin to peri-wound (tissue surrounding wound) with skin prep, fill the cavity with sponge	G 590	G590: Promptly alert the physician to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Plan of Correction: •Regarding the LPN: Director of Nursing had a phone and then in-person meeting with BT LPN March 12, and 15 2021. Initial discipline included a verbal and written warning, employee subject to termination. DON provided verbal education with BT-to fully and thoroughly review emails sent by RN Case Manager on every new patient, and review of the referral docs, prior to seeing any new patient for wound care. Additionally, if BT has questions, she is to seek answers well before her scheduled visits for new wound care patients. If there are new orders for wound patients (updated/changed), she is to ensure she has reviewed such orders prior to her scheduled visit. Immediate action taken was to remove BT from all wound vacuum patient visits. Subsequently, we also have removed BT from all wound care visits until the assigned extra education can be completed, wound documentation training completed, and a competency testing review completed. BT will be supervised onsite the first time BT does any wound care post 4/12/202 BT again met with Director of Nursing subsequently on April 13, 2021 and was assigned additional education. BT will be reviewing 2-4 webinars/trainings from WOCN.ORG (Wound, Ostomy and/or Continence Nurses Society website) and/or NPIAP.com (National Pressure Ulcer Advisory Panel website) as well as choosing one article from the Wound Care Management magazine and will be writing a short summary for each one, explaining what she learned from each of them. BT will be attending the nursing wound care documentation training to be held 4/15/2021. All visits will be audited for 90 days. Following this, we will review/audit 5-10 visits per month once each quarter for a period of one year. •Coordination: We have developed a specific policy for Care Coordination for notifying providers when changes occur to meet the patient's needs and involve family, caregivers, the patient, the primary care provider and other health care providers in care coordination. All service providers involved in the care of a patient, including contracted health care professionals or other agencies, will be engaged in an effective interchange, reporting, and coordination of care regarding the patient. Services are integrated to assure that patient needs and factors affecting patient safety and treatment effectiveness are coordinated among all health care providers serving the patient. All such coordination of care will be documented in the patient record. Wound Care Policy: We have developed a wound care policy that addresses the Plan of Care, assessments, documentation, coordination and education. Completed 4/11/21, in place effective 4/16/2021 •All patients receiving wound care will have a weekly Skilled Nurse Visit by RN to inspect wound, document and measure. Effective 4/19/21 •Competency evaluations will be conducted for all clinicians related to wound care/wound vacuum prior to performing wound care independently. Effective 4/15/21; to be completed for current staff prior to 5/1/21	completion 4/27/2021

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G 590	Continued From page 3 foam, cover and secure with drape and apply tubing, then apply negative pressure at 125 mmHg (millimeters of mercury) continuously. In addition, the plan indicated nursing could use wet to dry dressing as an alternative as needed or until machine was available. The skilled nurse was also to perform wound care to a left ankle incision using normal saline, pat dry, cover with gauze, secure with tape, and cover with ACE bandage. An incident reported by the Home Care Agency to the State Agency dated 3/4/21, indicated on 3/1/21, P1 had been seen by the wound clinic team who discovered a sponge had been left in P1's wound at some point, causing it to grow into the tissue enough that it required surgical removal on 3/3/21. According to the facility's report, the agency administrator (who was also the director of nursing) questioned whether licensed practical nurse (LPN)-A had reviewed the wound vac and wound cares instructions thoroughly during a skilled nursing visit on 2/15/21, or subsequent visit, and as a result had removed only one sponge instead of two as she did not realize there had been two sponges in the stomach wound cavity. The administrator indicated during the investigation, registered nurse (RN)-A, a case manager who had completed the start of care (SOC) on 2/12/21, had taken a photo supporting no material had been left inside the wound cavity, before she applied two sponges inside the wound cavity prior to applying the wound vac. The report further indicated P1 had told the wound clinic nurse she no longer wanted the agency to provide wound care and preferred to go to the wound clinic three times a week, as P1 was upset that the agency likely caused this issue.	G 590	G590 Continued •Education: All clinicians will be educated regarding the new policy, including the importance of reviewing the Plan of Care, wound assessments, wound care, documentation and coordination/notifying provider of any changes. Completed 4/15/2021. •Audits: 100% of visit notes for patients currently receiving wound care beginning 4/15/2021 will be audited to verify that staff are documenting complete assessments, wound care, education with patients and coordination with providers for a period of three months.. Thereafter, quarterly clinical record audits of clients receiving wound care will be conducted for the following year. •100% of visit notes for patients receiving wound care will be audited for 90 days effective April 15, 2021. The frequency of said audits will be every 7-10 days, until July 13, 2021. Also, all of BT's visits will be audited every 7-10 days for the 90 days, ending July 13, 2021. We will then begin quarterly reviews of all visits, auditing 5-10 visits of each nurse monthly, and to include all types of visits. •The corrective actions which will be accomplished for those patients found to have been affected by the deficient practice include additional wound care documentation training (completed 4/15/2021). Unfortunately, we are not able to specifically provide specific corrective actions for LJ as she discharged immediately after the deficiency became known to writer (Koester). •However, for JP and TM, and other wound care patients, we will improve upon and continue to coordinate with the wound clinic to assure that the wound care being provided is effective, discuss the wound care plan with the patients to be sure that they understand it and understand 1) what symptoms should be reported, 2) to whom they should be reported, and 3) when they should be reported. We have a new Care Coordination Policy in effect as well as a Wound Care Management Policy effective April 15, 2021 •Prior to her first wound care patient, all the above will be complete, and a RN will complete a competency checklist with BT, LPN. BT will also have a RN Case Manager with her when she is assigned her first wound patient to supervise her ability and documentation during the first wound care visit. We will also be auditing visits (wound and non-wound) for the initial 90 days, and then again quarter. •I, Laura Koester, Director of Nursing, am responsible for implementing the POC, and the date by which the corrections (except the quarterly audits post 90-days) will be implemented is April 27, 2021.	4/27/2021

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G 590	Continued From page 4 During a review of P1's medical record the following was revealed: -A start of care progress noted documented by RN-A dated 2/12/21, referenced a SOC OASIS (Outcome and Assessment Information Set) assessment dated 2/12/21, indicating P1 had a recent surgery to her stomach for ventral hernia repair and the wound had been infected more than once with trouble healing. According to the note, during the visit RN-A indicated the wound showed no signs and symptoms of infection. RN-A indicated at the time of arrival into P1's home it was observed P1 had a wet to dry dressing in place because the wound vac had come off. The note indicated RN-A had removed the dressing, cleansed the wound with normal saline, patted the area dry, placed 2 pieces of sponge to the wound bed to cover the depth of the wound, covered sponge/wound with drape, cut hole in drape, applied wound vac to sponge, covered with drape and set the wound vac at 125 mmHg continuous. -A nursing visit note dated 2/15/21, indicated after LPN-A had removed two sponges from inside P1's wound, she measured the wound, cleansed the abdomenal wound with normal saline, cut a sponge cut to fit, applied a drape over the sponge, and the wound vac was attached to the drape with good suction. LPN-A documented P1's wound bed granulation was 100%, the drainage was serosanguinous (a substance comprised of both blood cells and serum) with moderate drainage amount, and documented the wound had a slight odor. The nursing visit note also indicated during the visit P1's abdominal surgical wound had been measured, with a moderate	G 590		

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G 590	Continued From page 5	G 590		

amount of serosanguinous drainage noted. The note did not include a description of the wound bed or surrounding tissue.

-A nursing visit note by LPN-A dated 2/17/21, documented the old dressings had been removed, the abdomen wound was cleansed with normal saline, the sponge was cut to fit, drape was placed over sponge, the wound vac was attached to drape and the suction was good. LPN-A further documented there were no concerns at the time.

-A nursing visit note documented by LPN-A dated 2/19/21, indicated P1's dressing had been removed with covering and sponges, and a slight odor was noted as present. It was also noted P1 had stated she had changed the canister (container in a wound vac for collecting drainage). The note indicated LPN-A had cleansed P1's abdomen wound with normal saline, a sponge was cut to fit, a drape placed over sponge, wound vac attached to drape and the suction was good.

-A communication note documented by RN-A dated 2/19/21, indicated RN-A had received a call from LPN-A who reported having received a call from P1 indicating she [P1] felt air in the dressing on her abdomen. RN-A stated she had called P1 back and asked if the wound vac had any alarms going off which P1 denied. The note indicated RN-A had instructed P1 to call back with further concerns and P1 had acknowledged understanding.

-A nursing visit note documented by LPN-A dated 2/22/21, indicated P1 was laying in bed for wound care, the old dressings were removed, and a slight odor was noted as present. The note

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FIRSTAT NURSING SERVICES	**2395 ARIEL STREET NORTH MAPLEWOOD, MN 55109**

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G 590	Continued From page 6 indicated P1 had stated she had changed the canister. LPN-A's note described the care, P1's abdomen wound was cleansed with normal saline, drape was then placed, hole cut to fit sponge, the sponge was cut to fit, the drape was placed over sponge, the wound vac was attached to the drape, and the suction was good. LPN-A documented there were no signs or symptoms of infection noted, and P1 was educated on signs/symptoms of infection. Additionally, LPN-A documented that during the visit P1's abdominal surgical wound had been measured and a moderate amount of serosanguinous drainage had been noted however, there was no documented description of the wound bed and surrounding tissue. -A communication note dated 2/22/21, indicated LPN-A had called the wound clinic and spoken to a nurse there who stated P1 needed to be seen by the surgeon, but did not indicate why LPN-A had contacted them. Further the note indicated when LPN-A had called the surgeon's office she was told P1 should be seen by the wound clinic instead. The note indicated LPN-A had called the wound clinic back again and was told by the wound clinic nurse they would be in touch with P1 to schedule a follow up appointment. The note did not indicate whether LPN-A had notified either the surgeon's office, or the nurse at the wound clinic of the odor noted in P1's wound. -A nursing visit note documented by LPN-A dated 2/24/21, indicated when P1's old dressings were removed, there was a slight odor noted to be present. The note indicated the abdomen wound was cleansed with normal saline, a drape was placed, the hole was cut to fit sponge, then the sponge was cut to fit, the drape was placed over	G 590		

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G 590	Continued From page 7	G 590		

sponge, was attached to the wound vac, and was suctioning good. LPN-A's note indicated there were no signs or symptoms of infection noted, and P1 was educated on signs/symptoms of infection. The note did not indicate whether LPN-A had asked P1 about any follow up from the wound clinic to verify an appointment had been made.

-A nursing visit note documented by LPN-A dated 2/26/21, indicated P1's old dressings were removed, the abdominal wound was cleansed with normal saline, the drape was placed, the hole was cut to fit sponge, the sponge was cut to fit, the drape was placed over sponge, and the wound vac was attached to the drape which was suctioning good. LPN-A's documentation did not indicate any assessment of the wound's odor. Further, the note indicated the skilled nurse was to follow up with P1's wound clinic about a follow up appointment scheduled for 3/1/21.

During an interview on 3/15/21, at 2:12 p.m. RN-A stated she had completed the SOC visist for P1 on 2/12/21, and at the time when she arrived, P1 had a wet to dry dressing in the abdominal wound with no wound vac attached. RN-A stated she took a photo of the wound which showed there was nothing inside the cavity. RN-A then stated she applied two pieces of sponge to the wound cavity after she had cleansed the wound and draped it appropriately then attached the wound vac. RN-A also stated after the SOC, LPN-A was assigned to conduct the follow up wound care visits. RN-A described P1's wound at the SOC, as not deep even at the deep part of the wound, the wound bed was pink, and the physician's order was to put two sponges in the deeper part of the wound. RN-A also stated there was no odor noted

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G 590	Continued From page 8 at the SOC. RN-A stated she had not been informed P1's wound had a "slight odor" during subsequent visits completed by LPN-A until P1 had gone to the clinic on 3/1/21. RN-A stated she would have expected LPN-A to notify her, or the medical provider right away to notify them there was an odor present. RN-A stated, "When there is anything out of the normal, nursing staff are to notify the case manager. When I see a new patient I will send a note and if there is wound care ordered, I will let the nurse know how the visit went. I sent a note to [LPN-A] on 2/13/21, to tell her how many sponges needed to be put into the wound." RN-A stated on 2/15/21, LPN-A had responded by text letting her know she hadn't had a chance to look at P1's orders before going to see P1, and hadn't seen the text until later that day. RN-A stated when she received LPN-A's response, she thought LPN-A had not read the orders before she went to see P1 and by the time she'd messaged LPN-A back, her visit was already completed. RN-A stated LPN-A swore she had not left any sponge in the wound. RN-A further stated the agency policy was all the nurses were supposed to review the wound orders which included the referral documents before completing wound care. During an interview on 3/15/21, at 2:49 p.m. LPN-A stated she provided wound care to P1 which involved a wound vac. LPN-A stated during a visit she would also review the patient's body systems and gather vital signs. LPN-A stated when she had called RN-A before the first visit with P1, she'd had a few questions about the orders but RN-A was not available, so she had just proceeded to do the visit. LPN-A stated when she first saw P1, she had applied 2 sponges into the abdominal wound after she'd cleansed the	G 590		

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G 590	Continued From page 9 wound. LPN-A then stated, "The wound was deep, and I had to use my finger to feel around, and I guess I missed the sponge. I was not able to see the base of the wound." LPN-A acknowledged in the initial and subsequent visits she had not documented how many sponges she had used, or removed from the wound bed. LPN-A also acknowledged she had not updated the RN-A, the case manager, when she first noted the wound had an odor. LPN-A stated, "I should do that [update the case manager] more often." LPN-A stated after she had noticed the odor, that was when she had called the surgeon and the wound clinic arrange to have P1 seen. LPN-A stated she had not followed through to make sure the wound clinic had gotten in contact with P1 timely. LPN-A also acknowledged she had not documented why she had contacted the wound clinic and the surgeon. LPN-A said she should have assisted P1 to follow up with the wound clinic during and after her visits on 2/22/21 and 2/24/21, as P1 had not heard from the wound clinic. LPN-A sated, "that was something I should have done." During an interview on 3/15/21, at 3:17 p.m. the administrator/DON (director of nursing) stated she would have expected the physician and the case manager to have been notified when LPN-A first noticed the odor from the wound 2/15/22. The administrator/DON stated she had not heard about anything regarding the wound until right P1's 3/1/21 wound clinic appointment when they discovered the sponge. The administrator/DON stated when she was made aware of the allegation she had initiated an investigation and interviewed both LPN-A and RN-A. The administrator/DON stated from her interviews, she believed LPN-A had not reviewed the wound	G 590		

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G 590	Continued From page 10	G 590		

care orders for P1 prior to making her first visit on 2/15/21. The administrator/DON stated she thought that may have been when the sponge was left in P1's abdominal wound cavity. The administrator/DON also stated following the incident she had also reached out to P1 but had been unsuccessful reaching her. She stated moving forward, part of the new process would be to ask LPN-A to make sure she reviewed the orders before a visit. The administrator/DON also stated she was going to require the RN to do one visit weekly for all patient's with wound care to make sure they were aware of the condition of the wounds. She also said the RN would be responsible to review the notes for improvement and provide education as needed. The administrator/DON stated currently the agency did not have anyone on a wound vac and said she was going to review LPN-A's nursing skills to make sure she was competent. She said she was going to have LPN-A report everything to the RN case manager per the agency's protocols. The administrator/DON stated, "We will be looking at our wound policies and documentation moving forward because we do not want this to happen again."

During an interview on 3/16/21, at 5:01 p.m. P1 stated initially she had been going to the wound clinic for her wound care but had fallen and broken her ankle so was not able to go out, so she was admitted to the agency for wound care. P1 stated the first time RN-A had come to do the SOC she had completed the wound care and applied the wound vac. P1 also stated RN-A had told her for subsequent visits, LPN-A would be completing the visits. P1 stated the first visit by LPN-A was on 2/15/21. P1 stated, "On Monday [2/15/21] when [LPN-A] came the first time, she

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G 590	Continued From page 11 took one sponge out and put two more in the wound." P1 said, "[LPN-A] took the top sponge and the top dressing off and put the dressing back with two sponges but never removed the other sponge. I didn't ask her because I thought she knew her job. I kept telling her my wound was smelling and then another week went by and at this time the wound looked like it was closed up and did not need the wound vac or wound care anymore I thought." P1 also stated LPN-A had seen her for two weeks, and in the third week on 3/1/21, when she [P1] went to the wound clinic, the nurse there asked her if she had noticed the odor of the wound. P1 said she told the nurse it had been smelling the previous weeks, and she and LPN-A were trying to figure out the smell. P1 stated, "During the wound clinic visit, the doctor saw the sponge and when they had tried to pull it out, it was breaking in pieces because the skin had grown over the sponge. They had to do surgery remove it. I don't know how she did not see the sponge because she stood over me looking into my stomach wound. You could see the sponge standing over me. I could tell there was something in my stomach and if she was standing over me, she had to have seen it. I had to go through another surgery to remove the sponge. She was supposed to help me to get better from the surgery I had in December, but now I am still not well." The agency's undated policy Nursing Services 24/7, directed the nurses to inform the physician, and other staff of changes in a client's condition/needs. In addition, the policy directed staff to coordinate services including referral to other services as needed, and services were to be furnished in accordance with the patient's specified plan of care which was accessible 24	G 590		

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G 590	Continued From page 12 hours a day, 7 days per week.	G 590		
G 710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on interview and document review, the agency failed to assess wounds as directed in the plan of care (POC), to show progress towards goals, for 3 of 3 patients (P1, P2, P3), reviewed who received wound care treatment as reviewed for wound care. Findings include: P1 was admitted to the agency on 2/12/21, with diagnoses which included infection following a procedure other surgical site, schizoaffective disorder and chronic pain syndrome. P1's plan of care for certification period 2/12/21 to 4/12/21, indicated P1 had three wounds on the left lateral ankle, medial left ankle and the abdomen from a hernia surgery. The plan of care also identified P1 received skilled nursing (SN) three times a week for eight weeks for wound care and one visit as needed in case the wound vacuum (device that decreases air pressure on wound to help in wound healing) had issues and the nurse needed to see P1. In addition, the plan of care indicated skilled nursing was to assess and perform a complete physical assessment with each visit with emphasis on wounds. During review of the skilled nursing visits completed by both the registered nurse (RN) and the licensed practical nurse (LPN) it was revealed	G 710	G710 G710: Providing services that are ordered by the physician as indicated in the plan of care. Plan of correction: •Education: Staff will be educated regarding the new wound care policy, including review of/compliance with the Plan of Care, assessments, wound care, documentation and coordination/notifying provider of any changes. 4/15/2021 •Audits: 100% of visit chart documents for patients receiving wound care will be audited beginning with notes dated 4/15/2021 and for a period of 3 months to verify that the Plans of Care are complete and specific related to wound care and assessments and that staff are documenting complete assessments, wound care, education with patients and coordination with providers. Thereafter, quarterly clinical record audits of clients receiving wound care will be conducted for the following year. •100% of charting records for patients receiving wound care will be audited for 90 days effective April 15, 2021. The frequency of said audits will be every 7-10 days, until July 13, 2021. Also, all of BT's visit notes will be audited every 7-10 days for the 90 days, ending July 13, 2021. We will then begin quarterly reviews of all visits, auditing 5-10 visits of each nurse monthly, and to include all types of visits. •The corrective actions which will be accomplished for those patients found to have been affected by the deficient practice include additional wound care documentation training (completed 4/15/2021). Unfortunately, we are not able to specifically provide specific corrective actions for LJ as she discharged immediately after the deficiency became known to writer (Koester). •However, for JP and TM, and other wound care patients, we will improve upon and continue to coordinate with the wound clinic to assure that the wound care being provided is effective, discuss the wound care plan with the patients to be sure that they understand it and understand 1) what symptoms should be reported, 2) to whom they should be reported, and 3) when they should be reported. We have a new Care Coordination Policy in effect as well as a Wound Care Management Policy effective April 15, 2021 •Prior to her first wound care patient, all the above will be complete, and a RN will complete a competency checklist with BT, LPN. BT will also have a RN Case Manager with her when she is assigned her first wound patient to supervise her ability and documentation during the first wound care visit. We will also be auditing visits (wound and non-wound) for the initial 90 days, and then again quarterly. •I, Laura Koester, Director of Nursing, am responsible for implementing the POC, and the date by which the corrections (except the quarterly audits post 90-days) will be implemented is April 27, 2021.	4/27/2021

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G 710	Continued From page 13	G 710		

although the skilled visits had been completed on 2/12/21, through 2/26/21, the wound documentation assessments did not include the undermining/tunneling (occurs when the tissue under the wound edges becomes eroded, resulting in a a pocket beneath the skin at the wound's edge), pain in the wound, tissue loss, wound edges, surrounding tissue description and the tissue type/color.

P2 was admitted to the agency on 12/13/19, with diagnoses which included pressure ulcer of left heel, stage 3 (full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia.) pressure ulcer of left ankle, stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling) and paraplegia (impairment in motor or sensory function of the lower extremities). P2's plan of care for the certification period of 12/7/20 to 2/4/21, and 2/5/21 to 4/5/21, indicated P2 received SN three times a week for wound cares. The plan of care also indicated the skilled nurse was to perform a complete physical assessment at each visit with emphasis on wounds.

During a review of the skilled nursing visit notes completed by both LPN's and RN's it was revealed although visits for both recertification periods had been completed on 12/7/20 through 3/15/21, the wound documentation assessments did not include the undermining/tunneling, pain in the wound, tissue loss, wound edges, surrounding tissue description and the tissue type/color.

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G 710	Continued From page 14 P3 was admitted to the agency on 1/25/21, with diagnoses which included Hidradenitis suppurativa (a condition that causes painful bumps under the skin in the hair roots near some of the sweat glands) and type 2 diabetes mellitus without complications. P3's plan of care for certification period of 1/25/21 through 3/25/21, identified P3 had recently had surgery to the back of his head for hidradenitis excision thus the back of his head was completely open. In addition, the plan of care indicated P3 received SN twice daily for wound care and directed the skilled nurse to perform a complete physical assessment each visit with emphasis on wounds. During a review of the skilled nursing visit notes completed by both LPN's and RN's it was revealed although visits had been completed on 1/25/21 through 3/15/21, the wound documentation assessments did not include the undermining/tunneling, pain in the wound, tissue loss, wound edges, surrounding tissue description and the tissue type/color. During an interview on 3/15/21, at 2:12 p.m. RN-A stated after she completed the start of care assessments the LPN's did the follow up weekly visits and would only fill in with vacations, sick days, busy schedules and recertification's. RN-A stated wound assessment and measurements was completed on Mondays and this was mostly completed by the LPN. RN-A stated she would assess the wound every 60 days with recertification's unless she had seen the patient on the day the wound was to be measured. RN-A reviewed all three patient medical records and verified the wound documentation on the wound flow sheet did not include the undermining/tunneling, pain in the wound, tissue	G 710		

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G 710	Continued From page 15	G 710		

loss, wound edges, surrounding tissue description and the tissue type/color. RN-A acknowledged the nurses were doing the assessments for the wounds however thought they may not be charting thoroughly as it was part of their job to assess and document the wounds accurately.

During an interview on 3/15/21, at 3:17 p.m. the administrator/director of nursing (DON) stated she was going to require the registered nurse to do one visit weekly for all the wounds just to make sure they were aware of the wound condition and the RN would review the notes for improvement and provide education as needed. The administrator/DON also stated "We will be looking at our wound policies and documentation moving forward because we do not want this to happen again."

The agency's undated Nursing Services 24/7 policy, directed the nurses to inform the physician, and other staff of changes in a client's condition/needs. In addition, the policy directed staff to coordinate services including referral to other services as needed and services were to be furnished in accordance with the patient's specified in the plan of care which was accessible 24 hours a day, 7 days per week.

Protecting, Maintaining and Improving the Health of All Minnesotans

April 7, 2021

Administrator
Firstat Nursing Services
2395 Ariel Street North
Maplewood, MN 55109

Re: Event ID: IV2511

Dear Administrator:

A survey of the Home Care Provider named above was completed on March 15, 2021 for the purpose of assessing compliance with State licensing regulations and to investigate a complaint. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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 organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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FIRSTAT NURSING SERVICES	**2395 ARIEL STREET NORTH** **MAPLEWOOD, MN 55109**

(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) COMPLETE DATE
0 000	Initial Comments On 3/15/21, an abbreviated survey was completed at your agency by the Minnesota Department of Health to conduct complaint investigations. Although no correction orders were issued, the following complaint was found to be SUBSTANTIATED: H8087009C (MN00070657).	0 000	G570 – G590 G570: Care planning, coordination of services and quality of care G590: Promptly alert the physician to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Plan of Correction: •Regarding the LPN: Director of Nursing had a phone and then in-person meeting with BT LPN March 12, and 15 2021. Initial discipline included a verbal and written warning, employee subject to termination. DON provided verbal education with BT-to fully and thoroughly review emails sent by RN Case Manager on every new patient, and review of the referral docs, prior to seeing any new patient for wound care. Additionally, if BT has questions, she is to seek answers well before her scheduled visits for new wound care patients. If there are new orders for wound patients (updated/changed), she is to ensure she has reviewed such orders prior to her scheduled visit. Immediate action taken was to remove BT from all wound vac patient visits. Subsequently, we also have removed BT from all wound care visits until the assigned extra education can be completed, wound documentation training completed, and a competency testing review completed. BT will be supervised onsite the first time BT does any wound care post 4/12/2021. • BT again met with Director of Nursing subsequently on April 13, 2021 and was assigned additional education. BT will be reviewing 2-4 webinars/trainings from WOCN.ORG (Wound, Ostomy and Continence Nurses Society website) and NPIAP.com (National Pressure Ulcer Advisory Panel website) as well as choosing one article from the Wound Care Management magazine and will be writing a short summary for each one, explaining what she learned from each of them. of the meeting. BT will be attending the nursing wound care documentation training to be held 4/15/2021. All visits will be audited for 90 days. Following this, we will review/audit 5-10 visits per month once each quarter for a period of one year. •Coordination: We have developed a specific policy on Coordination for notifying providers when changes occur to meet the patient's needs and involve family, caregivers, the patient, the primary care provider and other health care providers in care coordination. All service providers involved in the care of a patient, including contracted health care professionals or other agencies, will be engaged in an effective interchange, reporting, and coordination of care regarding the patient. Services are integrated to assure that patient needs and factors affecting patient safety and treatment effectiveness are coordinated among all health care providers serving the patient. All such coordination of care will be documented in the patient record. Effective 4/16/2021 •Wound Care Policy: We have developed a wound care policy that addresses the Plan of Care, assessments, documentation, coordination and education. Completed 4/11/21, in place effective 4/16/2021 •All patients receiving wound care will have a weekly SNV by RN for all patients receiving wound care. Effective 4/12/21 •Competency evaluations will be conducted for all clinicians related to wound care/wound vac prior to performing wound care independently. Effective 4/15/21; to be completed for current staff prior to 5/1/21	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], BSN, RN PHN

TITLE: Director of Nursing

(X6) DATE: 4/23/21