

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Red Wing Health Center Facility Address: 1412 W 4th Street			Report Number: H5223093	Date of Visit: October 3, 2016 Date Concluded: January 23, 2017		
			Time of Visit: 7:30 a.m 1:30 p.m.			
Facility City: Red Wing			Investigator's Name and Debora Palmer, RN/Spe			
State: Minnesota	ZIP: 55066	County: Goodhue				
Nursing Home						

Allegation(s):

It is alleged that a resident was neglected when s/he developed several unstageable pressure ulcers and Stage III/IV pressure ulcers while s/he was at the facility.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occured when facility staff failed to implement a resident's designated care plan interventions to heal pressure ulcers and prevent new pressure ulcers from developing. Although facility nurses were aware that the resident was resisting the care plan interventions, facility nurses failed to address any alternative approaches for effective wound management. The resident developed nine new pressure ulcers in four months, including several that became infected and exhibited serious characteristics such as tunneling with depth, exposing muscle and bone. The resident was hospitalized twice in four months with sepsis from wound infections.

The resident was admitted to the facility from another long-term care facility at the end of April 2016. At the time of admission, the resident had two pressure ulcers, an unstageable pressure ulcer on the sacrum $(2.7 \text{ cm} \times 1.5 \text{ cm} \times .4 \text{ cm})$ and a Stage II pressure ulcer on the right heel $(1.8 \text{ cm} \times 1 \text{ cm})$. The resident has complete paraplegia and multiple sclerosis. The resident is unable to move his/her legs and has limited use of his/her arms. The resident is dependent for bed mobility and transfers. The resident can use an electric wheelchair independently which the resident propels with a joy stick. The resident is alert and oriented.

The resident had an alternating air mattress on his/her bed and a pressure redistributing cushion in the electric wheelchair. Staff were supposed to turn and re-position the resident every two hours and offload the resident hourly per the resident's care plan, but these interventions were not carried out. There was no planned turning or re-positioning schedule for pressure redistribution and staff did not offer to turn or reposition the resident unless the resident requested it. The resident was expected to offload him/herself

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by reclining the backrest of the wheelchair, but the frequency of offloading was not monitored by staff. The nursing assistant care guides regarding the resident's daily care tasks were void of any interventions aimed at wound management, including turning, re-positioning, or offloading the resident. Nurses did not provide adequate oversight of the resident's daily care by nursing assistants or the resident's daily needs to heal wounds and prevent new wounds from developing.

Although staff stated that the resident consistently refused wound management interventions, there was no evidence that staff evaluated the inadequacy of interventions or assessed the resident's individualized needs for alternative interventions. At the end of June 2016, the resident was hospitalized with sepsis due to a sacral wound infection. The sacral pressure ulcer had deteriorated to Stage IV with exposed muscle and tunneling. During hospitalization, the resident was found to have four new pressure ulcers, including a Stage II pressure ulcer on the right hip (10 cm in diameter), a Stage II pressure ulcer on the left hip (6 cm in diameter), a Stage II pressure ulcer on the right ischium (2 cm x 2 cm), and a Stage II pressure ulcer on the right ischium (2 cm x 2 cm).

After the resident returned to the facility from the hospital, there was no evidence that staff re-evaluated the resident's care plan interventions to determine modifications necessary for wound management and skin integrity. There was no evidence that staff initiated structured care interventions, including possible behavioral strategies, to promote wound healing and prevent new skin breakdown.

In mid-September 2016, the resident was hospitalized again with sepsis due to wound infections. On hospital admission, the resident had eleven pressure ulcers. Four of eleven pressure ulcers had grossly deteriorated. The sacral pressure ulcer (12 cm x 10 cm) was unstageable with purulent foul drainage and macerated edges. The left hip pressure ulcer was unstageable (9 cm x 7 cm) with purulent foul drainage. The right hip pressure ulcer had deteriorated to Stage IV (12 cm x 12 cm x 1.5cm) with bone felt at the bottom of the wound bed. The right ischium pressure ulcer had deteriorated to Stage IV (6 cm x 5 cm x 6 cm) with muscle exposed. The resident also had seven additional pressure ulcers, including a Stage III pressure ulcer on the left lateral ankle (3.5 cm x 2.0 cm), five pressure ulcers classified as unstageable on the right posterior shoulder (5.0 cm x 4.0 cm), the right heel (2.0 cm x 2.0 cm x 2.5 cm), the left heel (2.2 cm x 1.2 cm), the left lateral foot (1.0 cm x 1.5 cm), the right medial ankle (1.3 cm x 0.7 cm), and a Stage I pressure ulcer on the right lateral ankle. The resident was hospitalized for eight days due to the seriousness of the wounds.

After the resident returned to the facility from the hospital, there was no evidence that staff re-evaluated the resident's care approaches or made any changes in the resident's daily care routine. At the time of the onsite investigation, staff were not turning, re-positioning, or offloading the resident and the Nurse Manager of the resident's unit did not know how many wounds the resident had, what the condition of the resident's wounds were, or what the care plan interventions were to heal the resident's wounds and prevent new wounds from developing.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

Facility Name: Red	Wing Health Center	Report Number: H522309
☐ Abuse	Neglect Neglect	☐ Financial Exploitation
Substantiated Sub	☐ Not Substantiated	☐ Inconclusive based on the following information:
	ors" in Minnesota Statutes, sec ☐ Individual(s) and/or ☒ Fa	tion 626.557, subdivision 9c (c) were considered and it was cility is responsible for the
☐ Abuse		loitation. This determination was based on the following:
•	rganized systems for wound mursing oversight of resident ca	nanagement, care plan implementation, evaluation of care re.
substantiated against possible inclusion of	t an identified employee, this ref f the finding on the abuse regis	to appeal the maltreatment finding. If the maltreatment is eport will be submitted to the nurse aide registry for try and/or to the Minnesota Department of Human Services provisions of the background study requirements under
Compliance:		
The facility was four	•	utes, section 626.557) – Compliance Met ate Statutes for Vulnerable Adults Act (MN Statutes, sued.
		42 CFR, Part 483, subpart B) - Compliance Not Met or Long Term Care Facilities (42 CFR, Part 483, subpart B),
Deficiencies are issu	ed on form 2567: 🗵 Yes	□ No
(The 2567 will be av	ailable on the MDH website.)	
		s Chapter 4658) - Compliance Not Met Nursing Homes (MN Rules Chapter 4658) were not met.
State licensing order	rs were issued: 🕱 Yes	□ No
(State licensing orde	ers will be available on the MD	H website.)
•	ters 144 & 144A – Compliance nder State Statues for Chapter	Not Met - Compliance Not Met s 144 &144A were not met.
State licensing order	rs were issued: X Yes	□ No
(State licensing orde	ers will be available on the MD	H website.)
•	nt harm was cited at F314 during by L&C on 09/28/16	ng the facility's annual certification survey of 08/05/16,

Facility Name: Red Wing Health Center	Report Number: H52230
Facility Corrective Action: The facility took the following corrective action(s):	
Definitions:	
Minnesota Statutes, section 626.5572, subdivision 17 - Neglect "Neglect" means:	
(a) The failure or omission by a caregiver to supply a vulnerable a but not limited to, food, clothing, shelter, health care, or supervision wh	edult with care or services, including ich is:
(1) reasonable and necessary to obtain or maintain the vulnerabl or safety, considering the physical and mental capacity or dysfunction of	le adult's physical or mental health f the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.	
(b) The absence or likelihood of absence of care or services, inclucion clothing, shelter, health care, or supervision necessary to maintain the possible adult which a reasonable person would deem essential to obtain adult's health, safety, or comfort considering the physical or mental capacular vulnerable adult.	physical and mental health of the Itain or maintain the vulnerable
Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated "Substantiated" means a preponderance of the evidence shows that an maltreatment occurred.	
The Investigation included the following: <u>Document Review</u> : The following records were reviewed during the	investigation:

Report Number: H5223093

▼ Medical Records

▼ Medication Administration Records

Care Guide

Nurses Notes

X	Assessments									
X	Physician Orders									
X										
×										
X										
X	Skin Assessments									
×	Laboratory and X-ray Reports									
X	ADL (Activities of Daily Living) Flow Sheets									
	er pertinent medical records:									
X	Hospital Records									
Add	litional facility records:									
X	Staff Time Sheets, Schedules, etc.									
×	Facility Policies and Procedures									
Nur	mber of additional resident(s) reviewed: One plus three residents reviewed by L&C on 09/28/16.									
	re residents selected based on the allegation(s)? Yes No N/A									
	cify:									
-	re resident(s) identified in the allegation(s) present in the facility at the time of the investigation?									
Y										
_	cify:									
эрс										
Inte	erviews: The following interviews were conducted during the investigation:									
Inte	rview with complainant(s) Yes No N/A									
Spe	cify:									
If ur	nable to contact complainant, attempts were made on:									
Dat	e: Time: Date: Time: Date: Time:									
Inte	rview with family: O Yes O No N/A Specify: Attempts to interview family were unsuccessful									
Did	you interview the resident(s) identified in allegation:									
⊙ Y	/es O No O N/A Specify:									
Did	you interview additional residents? Yes No									
Tota	al number of resident interviews:Two									
Inte	rview with staff: Yes No N/A Specify:									

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Ten	nessen Warnings								
Teni	nessen Warning given as required: Yes No								
Tota	al number of staff interviews: Six								
Phys	sician Interviewed: O Yes No								
Nurs	se Practitioner Interviewed: Yes No								
Phys	sician Assistant Interviewed: Yes No								
Inte	rview with Alleged Perpetrator(s): Yes No N/A Specify:								
Atte	mpts to contact:								
Date	e: Time: Date: Time: Date: Time:								
If ur	able to contact was subpoena issued: O Yes, date subpoena was issued No								
Wer	e contacts made with any of the following:								
	Emergency Personnel 🗵 Police Officers 🗌 Medical Examiner 🗌 Other: Specify								
(A)									
(Obs	ervations were conducted related to: Wound Care								
	Personal Care								
X	Nursing Services								
X	Infection Control								
X									
X	Use of Equipment Cleanliness								
X									
X	Dignity/Privacy Issues								
X	Safety Issues								
X	Facility Tour Other Turning Repositioning and Offloading								
X	Other: Turning, Re-positioning, and Offloading								
Was	any involved equipment inspected: Yes No N/A								
	Was equipment being operated in safe manner: Yes No N/A								
Wer	e photographs taken: O Yes O No Specify:								

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Facility Name: Red Wing Health Center Report Number: H5223093

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Red Wing Police Department

Goodhue County Attorney

Red Wing City Attorney

PRINTED: 11/04/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		045000				С	
		245223	B. WING			10/	31/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER				1412 WEST FOURTH STREET		
				F	RED WING, MN 55066		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 000	INITIAL COMMENT	rs	FC	000			
	An abbreviated sta	ndard survey was conducted					
		laint #H5223093. The					
	following deficiency	is issued:					
		ed in ePOC and therefore a					
		uired at the bottom of the first					
	submission of the F	567 form. Electronic					-
	verification of comp						
F 314			F3				
SS=G	` ,		, ,	, , -+			
33-4	, , , , , , , , , , , , , , , , , , , ,						
	Based on the comp	rehensive assessment of a					
		must ensure that a resident					
		lity without pressure sores					
		ressure sores unless the					
		condition demonstrates that					
		ble; and a resident having eives necessary treatment and					
		healing, prevent infection and					
	prevent new sores f						
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	This REQUIREMEN	NT is not met as evidenced					
	by:						
	Based on observat	ion, interview, and document					
k.	review, the facility is	ailed to provide necessary healing of pressure ulcers					
		essure ulcers from developing					
		reviewed (R1), who was					
		lity with two pressure ulcers					
		additional pressure ulcers.					
	PETER ATT. C. C. C. C.	-					
	Findings include:						
	R1's medical record	d was reviewed and indicated					
		ed to the facility on 04/29/16					
		•					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		245223	B. WING			1	31/2016
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066			01/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 314	from another long-t admission, R1 had an unstageable precm x 1.5 cm x .4 cm pressure ulcer on hR1 has complete pasclerosis. R1 is unalimited use of his armobility and transfer wheelchair independance joy stick. R1 is ale 15/15 on the admis R1's initial care planthat R1 had an alter (APM) on his bed a cushion in his wheel R1 every 2-3 hours (frequency not specific perform R1's daily at the give R1 a dietary promote wound heaves poor. R1's gen The nurse's notes to indicated that R1 white interventions to heave in the wheelchait down in bed to chare the was no docutask sheets that any redistribute pressur declined by R1. On 06/13/16, staff of analysis with R1 no with "wound care" wound healing, devited the staff of analysis with R1 no with "wound care" wound healing, devited the staff of analysis with R1 no with "wound care" wound healing, devited the staff of a staff of analysis with R1 no with "wound care" wound healing, devited the staff of a staff of analysis with R1 no with "wound care" wound healing, devited the staff of a st	erm care facility. At the time of two pressure ulcers. R1 had ssure ulcer on his sacrum (2.7 m). R1 also had a stage II is right heel (1.8 cm x 1 cm). araplegia and multiple able to move his legs and has tms. R1 is dependent for bed ars. R1 can use an electric dently, which R1 propels with ert and oriented, scoring a sion BIMS assessment. In, dated 05/24/16, indicated mating air pressure mattress and a pressure redistributing elchair. Staff were to reposition and encourage R1 to offload cified). Facility nurses were to wound treatments. Staff were protein supplement to aling as R1's nutritional status eral mood was "friendly." Through mid-June 2016 as noncompliant with care all his wounds. R1 liked to stay and declined to laying positions until evening, mentation on R1's daily care and care interventions to the were offered to R1 and and conducted a benefit/risk ting that R1 was noncompliant which placed R1 at risk for elopment of additional and death. The Explanation of the eath.	F3	314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245223	B. WING				C 31/2016	
	PROVIDER OR SUPPLIER	1		1	STREET ADDRESS, CITY, STATE, ZIP CODE 412 WEST FOURTH STREET RED WING, MN 55066	1 10/	31/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOFICIENCY)	BE	(X5) COMPLETION DATE	
F 314	Risk and Benefits s sign the document "Resident says we worse." There was no evide care strategies at a R1's compliance winterventions. From the time of R the time of the inveguides used by nur care to R1 were vo and offloading interassistant care guidat wound healing of in conflict with R1's The medical provid 06/28/16, indicated 06/26/16 - 06/28/16 wound infection, whospitalization. R1's deteriorated to Stagtunneling. During heave four new presadmission. R1 had ulcer on his right hideveloped a Stage (6 cm in diameter) during hospitalization. R1 had develop the right ischium discharged back to for ten days with reevaluated in a Would in	sheet noted that R1 refused to with a staff entry that cause his wounds to get ence that staff re-evaluated my time, in attempt to gain ith wound healing 1's admission on 04/29/16 to stigation on 10/03/16, the care sing assistants who deliver id of any turning, repositioning, ventions. The nursing e had no interventions aimed r wound prevention, which was	F3	:14				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C		
		245223	B. WING		ı	31/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	1 10/	51/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	on 06/28/16, there addressed R1's new interventions, include strategies, to prome new skin breakdow measures for week wound specialist, the oversight regarding assistants. The medical provide 08/08/16, indicated further deteriorated pressure ulcer deteriorated pressure ulcer on hand 10 cm in diameter to Stage II pressure ulcer on hand 10 cm in diameter to Stage II pressure ulcer on hand 10 cm in diameter to Stage II pressure ulcer on hand 11's Stage II pressure ulcer on hand 10 cm in diameter to stage II pressure ulcer on the determine modification in the medical provide determine modification management and such in the medical provide on the pressure ulcer on hand in the medical provide on the pressure ulcer on hand in the medical provide on the pressure ulcer on hand in the medical provide on the pressure ulcer on hand in the press	to the facility from the hospital was no evidence that staff ed for structured care ding possible behavioral ote wound healing and prevent n. Although the facility initiated ly wound monitoring by a here was no evidence of nurse R1's daily care by nursing er's progress notes, dated that R1's pressure ulcers had that R1's pressure ulcers had a R1's Stage IV sacral riorated to 11.5 cm x 6.5 cm x backing. R1's Stage II is right hip deteriorated from the o 12 cm x 8 cm x 1 cm. R1's leer on his left hip deteriorated ter to 9 cm x 5 cm x 0.2 cm. The ulcers on his bilateral riorated to include depth. There was no evidence that are plan interventions to tions necessary for wound	F 31	4		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245223	B. WING				C 24 /2016
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER			I	STREET AI	DDRESS, CITY, STATE, ZIP CODE ST FOURTH STREET NG, MN 55066	1 10/	31/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD IOSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	medical provider nowith poor appetite a provider documents the importance of repressure on the word on the medical provide 09/16/16, indicated evaluated R1 in rescondition, which was mentation, a low-grayellowish-purulent for sacral wound. The rescondition wound culture and responsible appointment with G for further evaluation. The nurse's notes, or R1's wound culture p.m., showing gram bacteria. At 4:31 p.	oted that R1 was malnourished and poor intake. The medical sed that she educated R1 about expositioning to reduce unds. The progress notes, dated that the medical provider ponse to R1's change in some characterized by decreased ade fever, and coul-smelling drainage from the medical provider ordered a noted that R1 had an eneral Surgery on 09/20/16 n. The dated 09/20/16, indicated that results came back at 1:09 negative and gram positive m. on 09/20/16, R1 was ospital when his blood	F3	14			
	hospitalized from 09 metabolic encephale R1 had numerous p drainage and under hospital admission, ulcers. Four of elever grossly deteriorated was unstageable (12 foul drainage and m pressure ulcer was with purulent foul drainage and m pressure ulcer had com x 12 cm x 1.5 cm	tion indicated that R1 was 0/20/16 to 09/28/16 with opathy secondary to sepsis. ressure ulcers with purulent lying osteomyelitis. On R1 had eleven pressure en pressure ulcers had: R1's sacral pressure ulcer 2 cm x 10 cm) with purulent acerated edges; R1's left hip unstageable (9 cm x 7 cm) ainage; R1's right hip deteriorated to Stage IV (12 n) with bone felt at the bottom la's right ischium pressure					

AND BLAN OF CODDECTION DENTIFICATION NUMBER		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245223	B. WING			į.	C 31/2016
	PROVIDER OR SUPPLIER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 112 WEST FOURTH STREET ED WING, MN 55066	1 10/	31/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	ulcer had deteriorat 6 cm) with muscle of other pressure ulcer on the 2.0 cm). R1 had five unstageable that we posterior shoulder (heel (2.0 cm x 2.0 cm x 1.2 cm), the learning and the right lateral anking the right later	ed to Stage IV (6 cm x 5 cm x exposed. R1 also had seven rs. R1 had a Stage III ne left lateral ankle (3.5 am x expressure ulcers classified as ere observed on the right 5.0 cm x 4.0 cm), the right rm x 2.5 cm), the left heel (2.2 oft lateral foot (1.0 cm x 1.5 nedial ankle (1.3 cm x 0.7 cm). a Stage I pressure ulcer on e. The site visit on 10/03/16 was in bed on his back in a n 7:45 a.m. to 10:05 a.m., at rolled to his right side so the completed. Only half of R1's during the day shift and the pounds are treated during the day shift and the counds are treated during the day shift and the pounds are treated during the day shift and the counds are treated during the day shift and the pounds are treated during the day shift and the roximately 40 minutes. The area cere was consistent with roximately 40 minutes. The area cere was consistent with roximately 40 minutes. The area cere was realized for pain prior vinced during dressing	F3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245223	B. WING			C	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER			B. Wille	STREET ADDRESS, CITY, STATE, ZIP COD 1412 WEST FOURTH STREET RED WING, MN 55066		0/31/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 314	that staff do help his only when he asks when he starts hurt position too long. Tare not scheduled on when R1 was in the the opportunity to occasions when starts his wheelchair back position, staff don't later to the wheelch involuntarily the reresored being alone in the wheelchair as is his only means of socialization. R1 was serious decubiti. Ratio the facility's "lack Interviews were conwho were assigned the investigation of An interview was converted by the investigation of An interview was converted by the investigation of	them to do it which is mainly ting from sitting or laying in one imes for R1's position changes or consistent like they were hospital. Staff rarely offer R1 change positions. On aff have transferred R1 from to bed to offload in a different want to re-transfer him again hair so he has to stay in bed mainder of the day. R1 gets in his room. R1 likes to be up as much as possible because it if independence and as aware that he has multiple, it stated he got "bedsores" due to attention" to his needs. Inducted with three of four staff to work on R1's unit during 10/03/16. Inducted with LPN/C on mm. LPN/C was assigned to work on R1's unit during 10/03/16. Inducted with LPN/C on mm. LPN/C did not know if R1 my position changes the while R1 was in bed. LPN/C ally cooperates with position does not cooperate with fier he is up in the wheelchair. Designed to recline back and recline back to offload en o designated times that to offload but LPN/C reminds sible. R1 can independently tilt	F3	314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
245223			B. WING			C 10/31/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1412 WEST FOURTH STREET RED WING, MN 55066	P CODE	1 10/	31/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 314	was assigned to R1 stated that R1 was during the morning scheduled times to R1. Sometimes R1 bed. R1 is able to i when he is up in the the wheelchair's bar frequency in which nursing assistants of changes. R1 stays R1 likes to sit outsid with other residents. An interview was contology to a care on 10/03/16 at 11:00 at R1's care on 10/03/16 at 11:00 at R1's care. NA/E did be turned and re-posted about a scheup in the wheelchair term offloading mean explained to NA/E, I offload himself by utip back. The nursing the frequency that F An interview was contology of the contology of	in 10/03/16 at 10:45 a.m. NA/D is care on 10/03/16. NA/D not turned or re-positioned of 10/03/16. There are no turn, re-position, or offload will ask to be boosted up in independently offload himself wheelchair by tipping back ckrest. NA/D did not know the R1 offloaded himself. The do not monitor R1's position up in the wheelchair all day. He in the wheelchair and visit with the NA/E was not assigned to 16 but NA/E helped with R1's 0/03/16 and is familiar with not know if R1 is supposed to sitioned. When NA/E was dule to offload R1 when R1 is r, NA/E did not know what the ant. When offloading was NA/E stated that R1 can sing his wheelchair control to g assistants do not monitor	F 3	114			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245223		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245223	B. WING			C	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP (1412 WEST FOURTH STREET RED WING, MN 55066		0/31/2016	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 314	had a census of 30 An interview was co 10/03/16 at 12:10 proutinely refused cahis best interest to hat resident refusa documented each ti offered intervention R1's care refusals was daily care task shee R1's nursing assistating interventions for turn offloading R1 to recinconsistent with R1 An interview was concompleted she has evaluated she has eval	residents. Inducted with RN/DON/A on .m. RN/A stated that R1 re interventions that were in neal his wounds. RN/A stated its for care were to be ime a resident refused an .RN/A acknowledged that were not documented on R1's sts. RN/A acknowledged that ant care guide lacked any ning, re-positioning, or distribute pressure, which was 's care plan. Inducted with Medical 10/19/16 at 1:19 p.m. MP/F uated R1's wounds on s. R1's wounds have as developed additional refuses to comply with care at wound improvement. R1 inderstand the severity of his sit up in the wheelchair all the wheelchair to offload is imal offloading. R1 needs to with designated position in the pressure redistribution. Offer R1 opportunities for nig, and offloading and MP/F aff were not implementing or entions. It is the responsibility is sess R1's behavioral treatment interventions and nat foster R1's compliance, I contract or a contingency now if alternative strategies	F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245223		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			C 40/04/0046		
	PROVIDER OR SUPPLIER	4		STREET ADDRESS, CITY, STATE, ZIP COD 1412 WEST FOURTH STREET RED WING, MN 55066		10/31/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 314	Ulcers, dated Febru person in bed: Cha hours or more frequ in a chair: Change The care process s stabilize, reduce, or factors; to monitor t	on Prevention of Pressure uary 2014, indicated "For a nge position at least every two uently if needed. For a person position at least every hour. should include efforts to remove underlying risk the impact of the interventions; atterventions as appropriate."	F3	314			

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____ С B. WING 00149 10/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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:** A complaint investigation was conducted to Minnesota Department of Health is investigate complaint #H5223093. The following documenting the State Licensing correction orders are issued: Correction Orders using federal software.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

consistent with the Minnesota Department of

The facility has agreed to participate in the

electronic receipt of State licensure orders

TITLE

Tag numbers have been assigned to

Minnesota state statutes/rules for Nursing

(X6) DATE

Homes.

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

AND DEAN OF CORRECTION INCIDENTIFICATION NUMBER		1,			(X3) DATE SURVEY COMPLETED	
			A. BUILDING	:		
		00149	B. WING		C 10/31/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RED WI	NG HEALTH CENTER		ST FOURTH G, MN 5506			
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2 000	Health Informational http://www.health.stobul.htm The State delineated on the M Health orders being Although no plan of State Statutes/Rule "corrected" in the beindicate in the elect under the heading corders will be corrected.	Continued From page 1 Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. PL Th Th Th Th Th Th Th Th Th T		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, which 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		
2 900	MN Rule 4658.0525 Ulcers	Subp. 3 Rehab - Pressure	2 900			
	comprehensive resident of nursing services in	sores. Based on the dent assessment, the director must coordinate the arsing care plan which				
A.A.A.		enters the nursing home res does not develop				

PRINTED: 11/10/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00149 10/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1412 WEST FOURTH STREET RED WING HEALTH CENTER** RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 2 900 Continued From page 2 2 900 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, interview, and document review, the facility failed to provide necessary services to promote healing of pressure ulcers and prevent new pressure ulcers from developing for 1 of 1 residents reviewed (R1), who was admitted to the facility with two pressure ulcers and developed nine additional pressure ulcers. Findings include: R1's medical record was reviewed and indicated that R1 was admitted to the facility on 04/29/16 from another long-term care facility. At the time of admission, R1 had two pressure ulcers. R1 had an unstageable pressure ulcer on his sacrum (2.7 cm x 1.5 cm x .4 cm). R1 also had a stage II pressure ulcer on his right heel (1.8 cm x 1 cm). R1 has complete paraplegia and multiple sclerosis. R1 is unable to move his legs and has limited use of his arms. R1 is dependent for bed mobility and transfers. R1 can use an electric

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wheelchair independently, which R1 propels with a joy stick. R1 is alert and oriented, scoring a 15/15 on the admission BIMS assessment.

R1's initial care plan, dated 05/24/16, indicated that R1 had an alternating air pressure mattress (APM) on his bed and a pressure redistributing

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING		10/3) 1/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/3	1/2016
RED WIN	IG HEALTH CENTER		T FOURTH			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
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2 900	Continued From pa	ge 3	2 900			
	R1 every 2-3 hours	elchair. Staff were to reposition and encourage R1 to offload cified). Facility nurses were to				
	perform R1's daily v	wound treatments. Staff were				
	promote wound hea	protein supplement to aling as R1's nutritional status eral mood was "friendly."				
	The nurse's notes through mid-June 2016 indicated that R1 was noncompliant with care		·			
	up in the wheelchai	Il his wounds. R1 liked to stay r all day and declined to lay				
		nge positions until evening. mentation on R1's daily care				
		y care interventions to e were offered to R1 and				
	analysis with R1 no with "wound care" w wound healing, dev wounds, infection, c Risk and Benefits s sign the document was an analysis with R1 no with R1 n	conducted a benefit/risk ting that R1 was noncompliant which placed R1 at risk for elopment of additional or death. The Explanation of heet noted that R1 refused to with a staff entry that cause his wounds to get				
		ence that staff re-evaluated ny time, in attempt to gain th wound healing				
	the time of the investiguides used by nurst care to R1 were voi and offloading intervassistant care guide	I's admission on 04/29/16 to stigation on 10/03/16, the care sing assistants who deliver d of any turning, repositioning, ventions. The nursing a had no interventions aimed wound prevention, which was				

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MANE OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER SIMMARY STATEMENT OF DEFICIENCIES PREED REQUIATORY OR USC IDENTIFYING INFORMATION) PREED REQUIATORY OR USC IDENTIFYING INFORMATION) 2 900 Continued From page 4 in conflict with R1's care plan. The medical provider's progress notes, dated 06/28/16, indicated that R1 was hospitalized from 06/28/16 of 06/28/16 with sepsis due to a sacral wound infection, which was debrided during hospitalization. R1 had developed a Stage il pressure ulcer on his right hip (10 cm in diameter). R1 had developed a Stage il pressure ulcer on his right hip (10 cm in diameter). R1 had developed a Stage il pressure ulcer on his right him (2 cm x 2 cm). R1 had developed a Stage il pressure ulcer on his right him (2 cm x 2 cm). R1 had developed a Stage il pressure ulcer on the right isolating (2 cm x 2 cm). R1 had developed a Stage il pressure ulcer on the right isolating (2 cm x 2 cm). R1 had developed a Stage il pressure ulcer on the right isolating (2 cm x 2 cm). R1 was discharged back to the facility nor oral antibiotics for ten days with recommendations to be evaluated in a Wound clinic and follow-up with General Surgery for additional debridement. After re-admission to the facility from the hospital on 06/28/16, there was no evidence that staff addressed R1's need for structured care interventions, including possible behavioral strategies, to promote wound healing and prevent new skin breakdown. Although the facility initiated measures for weekly wound monitoring by a wound specialist. Here was no evidence of nurse oversight regarding R1's daily care by nursing assistants. The medical provider's progress notes, dated 08/08/16, indicated that R1's pressure ulceres had further deteriorated. R1's Stage IV stage II		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55068 2 900 RECOLATION OF LIST DESTRUCTION OF LIST OF PRECEDED BY FULL RECOLATORY OR LIST DESTRUCTION OF LIST OF PRECEDED BY FULL RECOLATORY OR LIST DESTRUCTION OF LIST OF PRECEDED BY FULL TAG 1 n conflict with R1's care plan. The medical provider's progress notes, dated 06/28/16, Indicated that R1 was hospitalized from 06/28/16, Indicated that R1 was hospitalized from 06/28/16 with sepsis due to a sacral wound infection, which was defined during hospitalization. R1's sacral pressure ulcer had deteriorated to Stage IV with exposed muscle and tunneling. During hospitalization, R1 was found to have four new large pressure ulcer on his left hip (6 cm in diameter) which was also debrided during hospitalization. R1 had developed a Stage II pressure ulcer on the right ischilum (2 cm x 2 cm). R1 had developed a Stage II pressure ulcer on the right ischilum (2 cm x 2 cm). R1 had developed a Stage II pressure ulcer on the right ischilum (2 cm x 2 cm). R1 was discharged back to the facility on oral antibiotics for ten days with recommendations to be evaluated in a Wound clinic and follow-up with General Surgery for additional debridement. After re-admission to the facility from the hospital on 06/28/16, there was no evidence that staff addressed R1's need for structured care interventions, including possible behavioral strategies, to promote wound healing and prevent new skin breakdown. Although the facility initiated measures for weekly wound monitoring by a wound specialist, there was no evidence of nurse oversight regarding R1's daily care by nursing assistants. The medical provider's progress notes, dated 08/08/16, indicated th		1		A. DOILDING.		C		
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PADVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PROVIDERS	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
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in conflict with R1's care plan. The medical provider's progress notes, dated 06/28/16, indicated that R1 was hospitalized from 06/26/16 - 06/28/16 with sepsis due to a sacral wound infection, which was debrided during hospitalization. R1's sacral pressure ulcer had deteriorated to Stage IV with exposed muscle and tunneling. During hospitalization, R1 was found to have four new large pressure ulcers since facility admission. R1 had developed a Stage II pressure ulcer on his right hip (10 cm in diameter). R1 had developed a Stage II pressure ulcer on his left hip (6 cm in diameter) which was also debrided during hospitalization. R1 had developed a Stage II pressure ulcer on his left hip (6 cm in diameter) which was also debrided during hospitalization. R1 had developed a Stage II pressure ulcer on the right ischium (2 cm x 2 cm). R1 had developed a Stage II pressure ulcer on the right ischium (2 cm x 2 cm). R1 was discharged back to the facility on oral antibiotics for ten days with recommendations to be evaluated in a Wound clinic and follow-up with General Surgery for additional debridement. After re-admission to the facility from the hospital on 06/28/16, there was no evidence that staff addressed R1's need for structured care interventions, including possible behavioral strategies, to promote wound healing and prevent new skin breakdown. Although the facility initiated measures for weekly wound monitoring by a wound specialist, there was no evidence of nurse oversight regarding R1's daily care by nursing assistants. The medical provider's progress notes, dated 08/08/16, indicated that R1's Stage IV sacral pressure ulcer deteriorated to 11.5 cm x 6.5 cm x	PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE	
pressure ulcer on his right hip deteriorated from	2 900	in conflict with R1's The medical provide 06/28/16, indicated 06/26/16 - 06/28/16 wound infection, whospitalization. R1's deteriorated to Stagtunneling. During he have four new large admission. R1 had ulcer on his right hip developed a Stage (6 cm in diameter) will during hospitalization. R1 had developed a Stage (6 cm in diameter) will pressure ulcer on cm). R1 had developed on the right ischium discharged back to for ten days with recevaluated in a Wound General Surgery for After re-admission to on 06/28/16, there waddressed R1's need interventions, includ strategies, to promonew skin breakdown measures for weekl wound specialist, thoversight regarding assistants. The medical provide 08/08/16, indicated further deteriorated. pressure ulcer determined pressure ulcer determined in a many required pressure ulcer determ	der's progress notes, dated that R1 was hospitalized from with sepsis due to a sacral nich was debrided during separate ulcer had ge IV with exposed muscle and ospitalization, R1 was found to be pressure ulcers since facility developed a Stage II pressure p (10 cm in diameter). R1 had II pressure ulcer on his left hip which was also debrided on. R1 had developed a Stage in his left ischium (2 cm x 2 oped a Stage II pressure ulcer in (2 cm x 2 cm). R1 was the facility on oral antibiotics commendations to be und clinic and follow-up with readditional debridement. It to the facility from the hospital was no evidence that staffed for structured care ding possible behavioral one wound healing and prevent in. Although the facility initiated by wound monitoring by a mere was no evidence of nurse in R1's daily care by nursing er's progress notes, dated that R1's pressure ulcers had increased. R1's Stage IV sacral criorated to 11.5 cm x 6.5 cm x packing. R1's Stage II	2 900	DEFICIENCY)			

Minnesota Department of Health

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING 00149 10/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 2 900 2 900 Continued From page 5 10 cm in diameter to 12 cm x 8 cm x 1 cm. R1's Stage II pressure ulcer on his left hip deteriorated from 6 cm in diameter to 9 cm \times 5 cm \times 0.2 cm. R1's Stage II pressure ulcers on his bilateral ischiums both deteriorated to include depth. There was no evidence that staff provided any further education to R1 about wound healing and wound prevention. There was no evidence that staff re-evaluated care plan interventions to determine modifications necessary for wound management and skin integrity. The medical provider's progress notes, dated 09/08/16, indicated that R1 had a "large deep pressure ulcer on his sacrum, significant pressure ulcers on both ischiums, large pressure ulcers over both hips, a pressure ulcer on the outside of one foot, and a new pressure ulcer further up his back...for some reason, the wound care specialist has not seen him for several weeks." The medical provider noted that R1 was malnourished with poor appetite and poor intake. The medical provider documented that she educated R1 about the importance of repositioning to reduce pressure on the wounds. The medical provider's progress notes, dated 09/16/16, indicated that the medical provider evaluated R1 in response to R1's change in condition, which was characterized by decreased mentation, a low-grade fever, and yellowish-purulent foul-smelling drainage from the sacral wound. The medical provider ordered a wound culture and noted that R1 had an appointment with General Surgery on 09/20/16

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for further evaluation.

The nurse's notes, dated 09/20/16, indicated that R1's wound culture results came back at 1:09

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: С B. WING 00149 10/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 2 900 2 900 Continued From page 6 p.m., showing gram negative and gram positive bacteria. At 4:31 p.m. on 09/20/16, R1 was transferred to the hospital when his blood pressure dropped to 88/56. Hospital documentation indicated that R1 was hospitalized from 09/20/16 to 09/28/16 with metabolic encephalopathy secondary to sepsis. R1 had numerous pressure ulcers with purulent drainage and underlying osteomyelitis. On hospital admission. R1 had eleven pressure ulcers. Four of eleven pressure ulcers had grossly deteriorated: R1's sacral pressure ulcer was unstageable (12 cm x 10 cm) with purulent foul drainage and macerated edges; R1's left hip pressure ulcer was unstageable (9 cm x 7 cm) with purulent foul drainage; R1's right hip pressure ulcer had deteriorated to Stage IV (12 cm x 12 cm x 1.5 cm) with bone felt at the bottom of the wound bed; R1's right ischium pressure ulcer had deteriorated to Stage IV (6 cm x 5 cm x 6 cm) with muscle exposed. R1 also had seven other pressure ulcers. R1 had a Stage III pressure ulcer on the left lateral ankle (3.5 am x 2.0 cm). R1 had five pressure ulcers classified as unstageable that were observed on the right posterior shoulder (5.0 cm x 4.0 cm), the right heel (2.0 cm x 2.0 cm x 2.5 cm), the left heel (2.2 cm x 1.2 cm), the left lateral foot (1.0 cm x 1.5 cm), and the right medial ankle (1.3 cm x 0.7 cm). In addition, R1 had a Stage I pressure ulcer on the right lateral ankle. Observation during the site visit on 10/03/16 established that R1 was in bed on his back in a supine position from 7:45 a.m. to 10:05 a.m., at which time R1 was rolled to his right side so

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wound care could be completed. Only half of R1's wounds are treated during the day shift and the other half of R1's wounds are treated during the

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C **B WING** 00149 10/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 Continued From page 7 2 900 evening shift. Wound care was observed to the left and right ischiums, right shoulder, and both feet which took approximately 40 minutes. Wound size and character was consistent with information documented in R1's 09/28/16 hospital record. Although R1 was medicated for pain prior to wound care, R1 winced during dressing changes to all wounds. An interview was conducted with R1 on 10/03/16 at 8:10 a.m. R1 immediately apologized for his appearance and stated that he did not have his teeth in because he needs staff assistance with personal care, which is typically done after the nurse completes his wound care around 9:30 a.m. R1 then gets up in his electric wheelchair via hoyer lift every day around 11:00 a.m. R1 described himself as "completely helpless" and reliant on staff assistance for all needs. R1 stated that staff do help him turn and re-position, but only when he asks them to do it which is mainly when he starts hurting from sitting or laying in one position too long. Times for R1's position changes are not scheduled or consistent like they were when R1 was in the hospital. Staff rarely offer R1 the opportunity to change positions. On occasions when staff have transferred R1 from his wheelchair back to bed to offload in a different position, staff don't want to re-transfer him again later to the wheelchair so he has to stay in bed involuntarily the remainder of the day. R1 gets bored being alone in his room. R1 likes to be up in the wheelchair as much as possible because it is his only means of independence and socialization. R1 was aware that he has multiple, serious decubiti. R1 stated he got "bedsores"due to the facility's "lack of attention" to his needs.

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Interviews were conducted with three of four staff who were assigned to work on R1's unit during

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00149 10/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 900 Continued From page 8 2 900 the investigation of 10/03/16. An interview was conducted with LPN/C on 10/03/16 at 8:55 a.m. LPN/C was assigned to R1's care on 10/03/16. LPN/C did not know if R1 had been offered any position changes the morning of 10/03/16 while R1 was in bed. LPN/C stated that R1 usually cooperates with position changes in bed but does not cooperate with position changes after he is up in the wheelchair. R1's wheelchair is designed to recline back and she reminds R1 to recline back to offload pressure. There are no designated times that LPN/C reminds R1 to offload but LPN/C reminds R1 as often as possible. R1 can independently tilt the wheelchair back to recline. An interview was conducted with Nursing Assistant (NA)/D on 10/03/16 at 10:45 a.m. NA/D was assigned to R1's care on 10/03/16. NA/D stated that R1 was not turned or re-positioned during the morning of 10/03/16. There are no scheduled times to turn, re-position, or offload R1. Sometimes R1 will ask to be boosted up in bed. R1 is able to independently offload himself when he is up in the wheelchair by tipping back the wheelchair's backrest. NA/D did not know the frequency in which R1 offloaded himself. The nursing assistants do not monitor R1's position changes. R1 stays up in the wheelchair all day. R1 likes to sit outside in the wheelchair and visit with other residents. An interview was conducted with NA/E on 10/03/16 at 11:00 a.m. NA/E was not assigned to R1's care on 10/03/16 but NA/E helped with R1's hoyer transfer on 10/03/16 and is familiar with R1's care. NA/E did not know if R1 is supposed to

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be turned and re-positioned. When NA/E was asked about a schedule to offload R1 when R1 is

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An interview was conducted with RN/DON/A on 10/03/16 at 12:10 p.m. RN/A stated that R1 routinely refused care interventions that were in his best interest to heal his wounds. RN/A stated that resident refusals for care were to be documented each time a resident refused an offered intervention, RN/A acknowledged that R1's care refusals were not documented on R1's daily care task sheets. RN/A acknowledged that R1's nursing assistant care guide lacked any interventions for turning, re-positioning, or offloading R1 to re-distribute pressure, which was inconsistent with R1's care plan.

wounds were, or what the care plan interventions were to heal R1's wounds and prevent new wounds from occurring. R1 was the only resident with wounds on the unit managed by RN/B, which

had a census of 30 residents.

stated she has evaluated R1's wounds on numerous occasions. R1's wounds have worsened and R1 has developed additional wounds because R1 refuses to comply with care interventions aimed at wound improvement. R1

An interview was conducted with Medical Provider (MP)/F on 10/19/16 at 1:19 p.m. MP/F

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to implement and properly revise a resident's care plan to heal pressure ulcers and prevent new pressure ulcers from developing. After being admitted to the facility, the resident developed nine new pressure ulcers in four months. including several that became infected and exhibited serious characteristics such as

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positions until evening. There was no

declined by the resident.

documentation on the resident's daily care task sheets that any care interventions to redistribute pressure were offered to the resident and

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

RED WIN	NG HEALTH CENTER	ST FOURTH S G, MN 55066		
(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
21850	Continued From page 13	21850		
	There was no evidence that staff re-evaluated care strategies at any time, in attempt to gain R1's compliance with wound healing interventions.			
	From the time of the resident's facility admission on 04/29/16 to the time of the investigation on 10/03/16, the care guides used by nursing assistants who deliver care to the resident were void of any turning, repositioning, and offloading interventions. The nursing assistant care guide had no interventions aimed at wound healing or wound prevention, which was in conflict with the resident's care plan.			
	The medical provider's progress notes, dated 06/28/16, indicated that the resident was hospitalized from 06/26/16 - 06/28/16 with sepsis due to a sacral wound infection, which was debrided during hospitalization. The resident's sacral pressure ulcer had deteriorated to Stage IV with exposed muscle and tunneling. During hospitalization, the resident was found to have four new large pressure ulcers since facility admission, including a Stage II pressure ulcer on his right hip (10 cm in diameter), a Stage II pressure ulcer on his left hip (6 cm in diameter), a Stage II pressure ulcer on his left ischium (2 cm x 2 cm), and a Stage II pressure ulcer on the right ischium (2 cm x 2 cm).			
	After re-admission to the facility from the hospital on 06/28/16, there was no evidence that staff addressed the resident's need for structured care interventions, including possible behavioral strategies, to promote wound healing and prevent new skin breakdown. Although the facility initiated measures for weekly wound monitoring by a wound specialist, there was no evidence of nurse			
	oversight regarding the resident's daily care by			

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The medical provider ordered a wound culture.

The nurse's notes, dated 09/20/16, indicated that the resident's wound culture results came back at 1:09 p.m., showing gram negative and gram

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ankle.

Observation during the site visit on 10/03/16 established that the resident was in bed on his back in a supine position from 7:45 a.m. to 10:05 a.m., at which time R1 was rolled to his right side so wound care could be completed. Wound care was observed to the left and right ischiums, right shoulder, and both feet which took approximately

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10/03/16 at 8:55 a.m. LPN/C was assigned to the resident's care on 10/03/16, LPN/C did not know if the resident had been offered any position changes the morning of 10/03/16 while the resident was in bed. LPN/C stated that the resident usually cooperates with position changes in bed but does not cooperate with position

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control to tip back. The nursing assistants do not

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AND BLAN OF CORRECTION INDESTRUCTION NUMBERS		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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21850	Continued From pa	ge 18	21850			
	himself.	ncy that the resident offloads			:	
	(RN)/B on 10/03/16 she has worked at and was unfamiliar not know how many what the condition or what the care plathe resident's woun from occurring. The resident with wound	the facility for only one month with the resident. RN/B did wounds the resident had, of the resident's wounds were, an interventions were to heal ds and prevent new wounds e resident was the only ds on the unit managed by census of 30 residents.	- 1			
	10/03/16 at 12:10 p resident routinely rewere in his best into stated that resident documented each toffered intervention resident's care refuthe resident's daily acknowledged that assistant care guide turning, re-positioni to re-distribute preswith the resident's care and the resident's care	onducted with Medical				
	stated she has eval on numerous occas have worsened and additional wounds to to comply with care improvement. The wheelchair all day.	10/19/16 at 1:19 p.m. MP/F duated the resident's wounds sions. The resident's wounds I the resident has developed because the resident refuses interventions aimed at wound resident likes to sit up in the Tipping back in the wheelchair ficient for optimal offloading.		·		

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A Suggested Method of Correction:

(1) Develop and implement a system to ensure resident care plans are implemented by all care givers; educate all care givers.

person in bed: Change position at least every two hours or more frequently if needed. For a person in a chair: Change position at least every hour. The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate."

- (2) Develop and implement a system to ensure that nursing assistant care guides are kept current and adequately reflect necessary care interventions; educate all care givers.
- (3) Develop and implement a system to ensure care plan interventions are modified when established care interventions have proven ineffective; educate licensed staff.
- (4) Develop and implement a system to ensure adequate nurse oversight of care to residents; educate licensed staff.

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Note	POST-CERTIFICATION REVISIT REPORT								
243223				ISTRUCTION				DATE	OF REVISIT
This report is completed by a qualified State surveyor for the Medicare, Medical 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 to corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or provision number and the identification prefix each previously shown on the CMS-2567 (prefix codes shown to the left of each requirement the survey report form). TIEM		JATION NUMBE	ID Wina					_{Y2} 1/24/2	017 _{Y3}
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FOLLOWUP TO SURVEY COMPLETED ON 10/31/2016 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES								OU IT /0	ES NO

STATE FORM: REVISIT REPORT DATE OF REVISIT MULTIPLE CONSTRUCTION PROVIDER / SUPPLIER / CLIA / **IDENTIFICATION NUMBER** A. Building 1/24/2017 B. Wing 00149 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF FACILITY 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form). ITEM DATE DATE DATE ITEM **ITEM** Y5 Y5 Y4 Y5 Y4 Y4 **ID Prefix** Correction Correction ID Prefix 21850 Correction ID Prefix 20900 MN Rule 4658.0525 MN St. Statute 144.651 Completed Completed Reg. # Completed Reg. # Reg. # Subd. 14 Subp. 3 12/01/2016 12/01/2016 LSC LSC LSC Correction ID Prefix Correction Correction ID Prefix ID Prefix Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC ID Prefix Correction **ID Prefix** Correction **ID Prefix** Correction Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC Correction ID Prefix **ID Prefix** Correction ID Prefix Correction Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC Correction **ID Prefix ID Prefix** Correction **ID Prefix** Correction Completed Completed Reg. # Completed Reg. # Reg. # LSC LSC LSC DATE **REVIEWED BY** DATE SIGNATURE OF SURVEYOR **REVIEWED BY** (INITIALS) STATE AGENCY DATE **REVIEWED BY** DATE TITLE **REVIEWED BY** CMS RO (INITIALS) CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF **FOLLOWUP TO SURVEY COMPLETED ON** UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO 10/31/2016