MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Red Wing Health Center	H5223093	October 3, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
1412 W 4th Street	7:30 a.m. - 1:30 p.m.	January 23, 2017
Facility City:	**Investigator's Name and Title:**	
Red Wing	Debora Palmer, RN/Special Investigator	

State:	ZIP:	County:
Minnesota	55066	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 cm x 1.5 cm x .4 cm) and a Stage II pressure ulcer on the right heel (1.8 cm x 1 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

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 left ischium (2 cm x 2cm), 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):

☐ Abuse ☒ Neglect ☐ Financial Exploitation
☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility lacked organized systems for wound management, care plan implementation, evaluation of care plan efficacy, and nursing oversight of resident care.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

A severity of resident harm was cited at F314 during the facility's annual certification survey of 08/05/16, which was corrected by L&C on 09/28/16.

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 adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of 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, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- ☒ Medical Records
- ☒ Care Guide
- ☒ Medication Administration Records
- ☒ Nurses Notes

- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Laboratory and X-ray Reports
- [x] ADL (Activities of Daily Living) Flow Sheets

Other pertinent medical records:

- [x] Hospital Records

Additional facility records:

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: One plus three residents reviewed by L&C on 09/28/16.

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

Interview with family: ○ Yes ◉ No ○ N/A Specify: Attempts to interview family were unsuccessf

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Two

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Six

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ◉ Yes ○ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☒ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Wound Care
☒ Personal Care
☒ Nursing Services
☒ Infection Control
☒ Use of Equipment
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Facility Tour
☒ 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

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Licensing & Certification

Minnesota Board of Examiners for Nursing Home Administrators

Minnesota Board of Nursing

The Office of Ombudsman for Long-Term Care

Red Wing Police Department

Goodhue County Attorney

Red Wing City Attorney

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	245223	A. BUILDING _____ B. WING _____	C 10/31/2016

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #H5223093. The following deficiency is issued: The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, 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	F 314		

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

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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 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 cushion in his wheelchair. Staff were to reposition R1 every 2-3 hours and encourage R1 to offload (frequency not specified). Facility nurses were to perform R1's daily wound treatments. Staff were to give R1 a dietary protein supplement to promote wound healing as R1's nutritional status was poor. R1's general mood was "friendly."

The nurse's notes through mid-June 2016 indicated that R1 was noncompliant with care interventions to heal his wounds. R1 liked to stay up in the wheelchair all day and declined to lay down in bed to change positions until evening. There was no documentation on R1's daily care task sheets that any care interventions to redistribute pressure were offered to R1 and declined by R1.

On 06/13/16, staff conducted a benefit/risk analysis with R1 noting that R1 was noncompliant with "wound care" which placed R1 at risk for wound healing, development of additional wounds, infection, or death. The Explanation of

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F 314	Continued From page 2 Risk and Benefits sheet noted that R1 refused to sign the document with a staff entry that "Resident says we cause his wounds to get worse." 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 R1's 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 R1 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 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 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 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.	F 314		

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F 314	Continued From page 3 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 pressure ulcers had further deteriorated. R1's Stage IV sacral pressure ulcer deteriorated to 11.5 cm x 6.5 cm x 3 cm and required packing. R1's Stage II pressure ulcer on his right hip deteriorated from 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 x 5 cm x 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	F 314		

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F 314	Continued From page 4 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 for further evaluation. The nurse's notes, dated 09/20/16, indicated that R1's wound culture results came back at 1:09 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	F 314		

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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 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 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

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F 314	Continued From page 6 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. Interviews were conducted with three of four staff who were assigned to work on R1's unit during 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	F 314		

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F 314	Continued From page 7	F 314		

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 be turned and re-positioned. When NA/E was asked about a schedule to offload R1 when R1 is up in the wheelchair, NA/E did not know what the term offloading meant. When offloading was explained to NA/E, NA/E stated that R1 can offload himself by using his wheelchair control to tip back. The nursing assistants do not monitor the frequency that R1 offloads himself.

An interview was conducted with RN Manager (RN)/B on 10/03/16 at 11:05 a.m. RN/B stated she has worked at the facility for only one month and was unfamiliar with many of the residents, including R1. RN/B did not know how many wounds R1 had, what the condition of R1's 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

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	245223	A. BUILDING _____ B. WING _____	C 10/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, 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) COMPLETION DATE
F 314	Continued From page 8 had a census of 30 residents. 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. An interview was conducted with Medical Provider (MP)/F on 10/19/16 at 1:19 p.m. MP/F 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 does not seem to understand the severity of his wounds. R1 likes to sit up in the wheelchair all day. Tipping back in the wheelchair to offload is not sufficient for optimal offloading. R1 needs to be offloaded in bed with designated position changes to maximize pressure redistribution. Staff should always offer R1 opportunities for turning, re-positioning, and offloading and MP/F was unaware that staff were not implementing or offering these interventions. It is the responsibility of nursing staff to assess R1's behavioral noncompliance with treatment interventions and develop strategies that foster R1's compliance, such as a behavioral contract or a contingency plan. MP/F did not know if alternative strategies had been attempted by staff.	F 314		

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F 314	Continued From page 9 The facility's policy on Prevention of Pressure Ulcers, dated February 2014, indicated "For a 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."	F 314		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5223093. The following correction orders are issued: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the 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.	2 000	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 VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop	2 900		

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2 900	Continued From page 2 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 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	2 900		

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2 900	Continued From page 3	2 900		

cushion in his wheelchair. Staff were to reposition R1 every 2-3 hours and encourage R1 to offload (frequency not specified). Facility nurses were to perform R1's daily wound treatments. Staff were to give R1 a dietary protein supplement to promote wound healing as R1's nutritional status was poor. R1's general mood was "friendly."

The nurse's notes through mid-June 2016 indicated that R1 was noncompliant with care interventions to heal his wounds. R1 liked to stay up in the wheelchair all day and declined to lay down in bed to change positions until evening. There was no documentation on R1's daily care task sheets that any care interventions to redistribute pressure were offered to R1 and declined by R1.

On 06/13/16, staff conducted a benefit/risk analysis with R1 noting that R1 was noncompliant with "wound care" which placed R1 at risk for wound healing, development of additional wounds, infection, or death. The Explanation of Risk and Benefits sheet noted that R1 refused to sign the document with a staff entry that "Resident says we cause his wounds to get worse."

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 R1's 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 R1 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

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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 06/26/16 - 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 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 pressure ulcers had further deteriorated. R1's Stage IV sacral pressure ulcer deteriorated to 11.5 cm x 6.5 cm x 3 cm and required packing. R1's Stage II pressure ulcer on his right hip deteriorated from	2 900		

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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 x 5 cm x 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 for further evaluation. The nurse's notes, dated 09/20/16, indicated that R1's wound culture results came back at 1:09	2 900		

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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 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	2 900		

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2 900	Continued From page 7 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. Interviews were conducted with three of four staff who were assigned to work on R1's unit during	2 900		

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2 900	Continued From page 8 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 be turned and re-positioned. When NA/E was asked about a schedule to offload R1 when R1 is	2 900		

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2 900	Continued From page 9	2 900		

up in the wheelchair, NA/E did not know what the term offloading meant. When offloading was explained to NA/E, NA/E stated that R1 can offload himself by using his wheelchair control to tip back. The nursing assistants do not monitor the frequency that R1 offloads himself.

An interview was conducted with RN Manager (RN)/B on 10/03/16 at 11:05 a.m. RN/B stated she has worked at the facility for only one month and was unfamiliar with many of the residents, including R1. RN/B did not know how many wounds R1 had, what the condition of R1's 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.

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.

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

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2 900	Continued From page 10 does not seem to understand the severity of his wounds. R1 likes to sit up in the wheelchair all day. Tipping back in the wheelchair to offload is not sufficient for optimal offloading. R1 needs to be offloaded in bed with designated position changes to maximize pressure redistribution. Staff should always offer R1 opportunities for turning, re-positioning, and offloading and MP/F was unaware that staff were not implementing or offering these interventions. It is the responsibility of nursing staff to assess R1's behavioral noncompliance with treatment interventions and develop strategies that foster R1's compliance, such as a behavioral contract or a contingency plan. MP/F did not know if alternative strategies had been attempted by staff. The facility's policy on Prevention of Pressure Ulcers, dated February 2014, indicated "For a 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." 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. (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	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	C 10/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 11 adequate nurse oversight of care to residents; educate licensed staff. (5) Conduct routine care audits to ensure compliance. (6) Document all corrective action taken. Time Period for Correction: Thirty (30) days.	2 900		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, neglect did occur when the facility failed 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	21850		

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21850	Continued From page 12 tunneling with depth, exposing bone and muscle. The resident's medical record indicated that the resident was admitted to the facility on 04/29/16 from another long-term care facility. At the time of admission, the resident had two pressure ulcers. The resident had an unstageable pressure ulcer on his sacrum (2.7 cm x 1.5 cm x .4 cm) and a stage II pressure ulcer on his right heel (1.8 cm x 1 cm). The resident has complete paraplegia and multiple sclerosis. The resident is unable to move his legs and has limited use of his 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, scoring a 15/15 on the admission BIMS assessment. The resident's care plan, dated 05/24/16, indicated that the resident had an alternating air pressure mattress (APM) on his bed and a pressure redistributing cushion in his wheelchair. Staff were to reposition the resident every 2-3 hours and encourage the resident to offload (frequency not specified). Facility nurses were to perform the resident's daily wound treatments. The resident's general mood was "friendly." The nurse's notes through mid-June 2016 indicated that the resident was noncompliant with care interventions to heal his wounds. The resident liked to stay up in the wheelchair all day and declined to lay down in bed to change positions until evening. There was no documentation on the resident's daily care task sheets that any care interventions to redistribute pressure were offered to the resident and declined by the resident.	21850		

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21850	Continued From page 13 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	21850		

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21850	Continued From page 14 nursing assistants. The medical provider's progress notes, dated 08/08/16, indicated that the resident's pressure ulcers had further deteriorated. The Stage IV sacral pressure ulcer deteriorated to 11.5 cm x 6.5 cm x 3 cm and required packing. The Stage II pressure ulcer on the resident's right hip deteriorated from 10 cm in diameter to 12 cm x 8 cm x 1 cm. The Stage II pressure ulcer on the resident's left hip deteriorated from 6 cm in diameter to 9 cm x 5 cm x 0.2 cm. The Stage II pressure ulcers on the resident's bilateral ischiums both deteriorated to include depth. 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 the resident 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." The medical provider's progress notes, dated 09/16/16, indicated that the medical provider evaluated the resident in response to the resident'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. 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	21850		

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21850	Continued From page 15 positive bacteria. At 4:31 p.m. on 09/20/16, the resident was transferred to the hospital when his blood pressure dropped to 88/56. Hospital documentation indicated that the resident was hospitalized from 09/20/16 to 09/28/16 with metabolic encephalopathy secondary to sepsis. The resident had numerous pressure ulcers with purulent drainage and underlying osteomyelitis. On hospital admission, the resident had eleven pressure ulcers. Four of eleven pressure ulcers had grossly deteriorated: The sacral pressure ulcer was unstageable (12 cm x 10 cm) 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 1.5 cm) 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 other pressure ulcers, including a Stage III pressure ulcer on the left lateral ankle (3.5 am x 2.0 cm) and 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), and the right medial ankle (1.3 cm x 0.7 cm). In addition, the resident had a Stage I pressure ulcer on the right lateral 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	21850		

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21850	Continued From page 16 40 minutes. Wound size and character was consistent with information documented in R1's 09/28/16 hospital record. An interview was conducted with the resident on 10/03/16 at 8:10 a.m. The resident described himself as "completely helpless" and reliant on staff assistance for all needs. The resident 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. The resident's position changes are not scheduled or consistent. Staff rarely offer the resident the opportunity to change positions. On occasions when staff have transferred the resident 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. The resident gets bored being alone in his room. The resident likes to be up in the wheelchair as much as possible because it is his only means of independence and socialization. The resident was aware that he has multiple, serious decubiti. The resident stated he got "bedsores"due to the facility's "lack of attention" to his needs. Interviews were conducted with three of four staff who were assigned to work on the resident's unit during 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 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	21850		

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21850	Continued From page 17	21850		

changes after he is up in the wheelchair. The resident's wheelchair is designed to recline back and she reminds the resident to recline back to offload pressure. There are no designated times that LPN/C reminds the resident to offload but LPN/C reminds the resident as often as possible. The resident 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 the resident's care on 10/03/16. NA/D stated that the resident was not turned or re-positioned during the morning of 10/03/16. There are no scheduled times to turn, re-position, or offload the resident. Sometimes the resident will ask to be boosted up in bed. The resident 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 the resident offloaded himself. The nursing assistants do not monitor the resident's position changes. The resident stays up in the wheelchair all day. The resident 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 the resident's care on 10/03/16 but NA/E helped with the resident's hoyer transfer on 10/03/16 and is familiar with the resident's care. NA/E did not know if the resident is supposed to be turned and re-positioned. When NA/E was asked about a schedule to offload the resident when the resident is up in the wheelchair, NA/E did not know what the term offloading meant. When offloading was explained to NA/E, NA/E stated that the resident can offload himself by using his wheelchair control to tip back. The nursing assistants do not

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21850	Continued From page 18 monitor the frequency that the resident offloads himself. An interview was conducted with RN Manager (RN)/B on 10/03/16 at 11:05 a.m. RN/B stated she has worked at the facility for only one month and was unfamiliar with the resident. RN/B 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 occurring. The resident was the only resident with wounds on the unit managed by RN/B, which had a census of 30 residents. An interview was conducted with RN/DON/A on 10/03/16 at 12:10 p.m. RN/A stated that the resident 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 the resident's care refusals were not documented on the resident's daily care task sheets. RN/A acknowledged that the resident's nursing assistant care guide lacked any interventions for turning, re-positioning, or offloading the resident to re-distribute pressure, which was inconsistent with the resident's care plan. An interview was conducted with Medical Provider (MP)/F on 10/19/16 at 1:19 p.m. MP/F stated she has evaluated the resident's wounds on numerous occasions. The resident's wounds have worsened and the resident has developed additional wounds because the resident refuses to comply with care interventions aimed at wound improvement. The resident likes to sit up in the wheelchair all day. Tipping back in the wheelchair to offload is not sufficient for optimal offloading.	21850		

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21850	Continued From page 19 The resident needs to be offloaded in bed with designated position changes to maximize pressure redistribution. Staff should always offer the resident opportunities for turning, re-positioning, and offloading and MP/F was unaware that staff were not implementing or offering these interventions. It is the responsibility of nursing staff to assess the resident's behavioral noncompliance with treatment interventions and develop strategies that foster the resident's compliance, such as a behavioral contract or a contingency plan. MP/F did not know if alternative strategies had been attempted by staff. The facility's policy on Prevention of Pressure Ulcers, dated February 2014, indicated "For a 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." 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. (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.	21850		

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21850	Continued From page 20 (5) Conduct routine care audits to ensure compliance. (6) Document all corrective action taken. Time Period for Correction: Thirty (30) days.	21850		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245223 (Y1)	A. Building B. Wing (Y2)	1/24/2017 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 12/01/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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 ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00149 Y1	A. Building B. Wing Y2	1/24/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 12/01/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 12/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
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 ☐ NO			

EVENT ID: XCU512