DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
St Ottos Care Center Inc			H5257008 and H5257009	February 8, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
920 Fourth Street SE			8:15 a.m. to 4:00 p.m.	November 15, 2017
Facility City:			**Investigator's Name and Title:**	
Little Falls			Lindsey Krueger, RN, Supervisor Lisa Ciesinski, RN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	56345	Morrison		

☒ **Nursing Home**

Allegation(s):

It is alleged that a resident was neglected when the facility staff failed to follow proper skin checks ordered by the physician. As a result, the resident sustained a pressure ulcer which needed surgical debridement.

- ☒ 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 occurred when the facility staff failed to follow physician orders, to remove the resident's walking boot daily, and assess the resident's skin. As a result, the resident developed a stage II pressure ulcer to the resident's right heel which required surgical debridement.

The resident had diagnoses that included a recent fracture of the right tibia and fibula. The resident needed assistance from one to two staff for activities of daily living. The resident needed a walking boot for his/her right lower extremity due to the recent fractures.

The resident went for a check-up to his/her physician due to the right tibia and fibula fracture. Orders were written by the resident's physician for staff to remove the resident's walking boot daily for skin checks. Nine days later when staff assessed the resident's right lower extremity, they noticed the resident's sock under the boot was wet and odorous. The walking boot and sock were removed, and a right heel pressure wound was observed. The wound measured to be 6.5 centimeters (cm) x 7.5 cm in size, purple in color, and showed poor circulation. Staff assessed the right heel to be mushy with white flaky skin around the perimeter of the wound. The physician saw the resident that day and transferred the resident to the

hospital later that same day. The resident was admitted to the hospital with a diagnoses of a decubitus ulcer. The resident's heel was debrided before the resident returned to the facility. The resident died approximately one month later.

The resident's death record indicated the resident's cause of death was chronic kidney disease and aspiration pneumonia.

When interviewed during the on-site visit, the resident stated that his/her foot rubbed the inside of the walking boot and it was very painful prior to the debridement. The resident stated she asked the facility nurse to look at his/her foot.

When interviewed, facility staff stated they were not following the physician orders to assess the resident's skin daily. Facility staff had cut off the toe area on the resident's sock underneath the walking boot and were assessing the resident's leg at the top of the boot and the toes at the bottom; however, the facility staff were not taking the resident's walking boot off to assess the skin under the boot.

After the incident, the facility educated staff on how to remove a walking boot and assess the skin underneath. The facility updated and provided training on their skin assessment policy to staff.

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 had policies in place for staff to follow regarding physician orders and skin assessments however multiple staff did not follow the physician order. The facility failed to have a system in place to ensure physician orders were followed.

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:

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:

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:

- [x] Medical Records
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports

Other pertinent medical records:

- [x] Hospital Records
- [x] Death Certificate

Additional facility records:

- [x] Resident/Family Council Minutes
- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Facility Policies and Procedures
- [x] Other, specify: Grievance Concerns

Number of additional resident(s) reviewed: Two

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 reporter(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

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

_____ _____ _____ _____ _____ _____

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

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: Three

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

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

☒ Cleanliness

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

The Office of Ombudsman for Long-Term Care

Little Falls Police Department

Morrison County Attorney

Little Falls City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245257	A. BUILDING _____ B. WING _____	R-C 10/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OTTOS CARE CENTER	920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A Post Certification Revisit (PCR) was completed, to follow up on deficiencies issued related to complaint H5257008 and H5257009. St. Otto's Care Center is in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{F 000}		

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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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5257008 and H5257009. As a result, the following deficiency is issued related to H5257008 and H5257009. 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(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of three resident's, (R1), reviewed received the necessary care to prevent pressure ulcers when staff failed to follow physician orders to assess the skin to R1's right lower extremity daily. R1 was harmed when she developed a stage II pressure ulcer on her right	F 314		

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F 314	Continued From page 1 heel requiring hospitalization. The findings include: R1's medical record was reviewed. R1 had diagnoses that included recent fracture of the right tibia and fibula. R1's significant change minimum data set dated 1/1/2017 indicated R1 had moderate cognitive impairment. R1's care plan edited on 1/25/2017 indicated R1 had impaired mobility and that R1 needed assistance with two staff for activities of daily living. A physician order dated 1/9/2017 at 5:20 p.m. indicated R1 was to continue with the imobilizer controlled ankle movement (CAM) boot at all times (to the right lower extremity) but that staff were to remove the boot daily for skin checks. Skin check assessments for 1/9/2017 thru 1/19/2017 indicated all skin assessments to R1's right lower extremity were completed by staff and twice on four of the days during that time period. A braden scale assessment completed on 1/16/2017 indicated R1 was at high risk for skin breakdown. A wound care data form dated 1/18/2017 indicated R1 had a wound to the right heel that was assessed to be a stage II pressure ulcer and was 6.5 centimeters (cm) x 7.5 cm. The wound was described as purple/maroon in color, did not blanche, and was mushy with white skin falling off. The pressure ulcer was foul smelling. R1's sock inside her CAM boot was wet, odorous, and was removed. A physician communication form dated 1/19/2017	F 314		

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F 314	Continued From page 2 indicated that facility staff noted two pressure areas on R1's right lower leg and heel, possibly from the air cast. Heel wound was 6.5 cm x 7.5 cm covered with eschar and had white peeling skin around the edges. A physician did come and see R1's wounds that day. A physician order dated 1/19/2017 instructed staff that R1 needed to see podiatry for debridement of heel ulcer. Further orders on 1/19/2017 at 5:45 p.m., instructed staff to transfer R1 to the emergency room per family request. Hospital discharge summary records indicate R1 was admitted to the hospital on 1/19/2017 with a diagnosis including decubitis ulcers involving R1's right lower extremity. R1 had a cast placed over her right heel with areas cut out for her ulcers to prevent further pressure injury to the heel. R1 was discharged back to the facility on 1/23/2017 A facility note on 1/23/2017 at 9:00 a.m., signed by the facility administrator, stated the administrator called R1's family member, (FM)-I. The administrator told FM-I that facility staff were not fully removing R1's CAM boot which would allow for a complete assessment of R1's skin to be completed. Facility staff were only performing CMS (circulation, motion, and sensation) assessments on R1's right lower extremity. The administrator acknowledged that this was not acceptable. The call ended on 1/23/17 at 9:10 a.m. R1's death worksheet, dated 2/24/17, indicated R1 passed away on 2/24/2017 from natural causes related to chronic kidney disease, recurrent aspiration pneumonia, and congestive heart failure.	F 314		

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F 314	Continued From page 3	F 314		

When interviewed on 2/8/2017 at 9:25 a.m. the director of nursing (DON) stated R1 had physician orders for staff to remove R1's CAM boot daily and perform skin checks. The DON stated that the pressure ulcer was found on R1's right heel on 1/19/2017. The DON spoke with facility staff to see how R1's skin checks were being done and found out that staff were treating R1's CAM boot like a cast and were not removing to check R1's skin under the boot. Staff were not assessing R1's heel. When R1's wound was found on 1/19/2017 it was covered in black eschar, wounds were seen that day by R1's physician. The DON acknowledged that facility staff were charting that skin assessments were completed per physician orders from 1/9/2017 to 1/19/2017; however, that was not accurate. R1's right lower extremity skin was not assessed for 10 days, even though the physician orders indicated facility staff were to assess daily.

When interviewed on 7/25/2017 at 2:45 p.m. FM-I stated that after admission to the hospital, R1 needed to have her right heel debrided. R1 had increased pain because of the ulcer and did not fully recover before passing away approximately one month later. FM-I stated that the facility administration admitted to FM-I that facility staff were not performing daily skin checks to R1's right lower extremity per physician orders.

A facility policy titled, Skin - Prevention and Treatment of Breakdown, dated 3/1/2010, provided staff with guidelines for prevention and treatment of skin problems. Measures for prevention of skin breakdown include daily inspection of a resident's skin, and for staff to report early signs of skin breakdown. Resident

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F 314	Continued From page 4 skin and clothing should be kept clean and dry.	F 314		

Minnesota Department of Health

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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 licensing order follow up was completed, to follow up on correction orders issued related to complaint H5257008 and H5257009. St. Otto's Care Center was found in compliance with state regulations.	{2 000}		

Minnesota Department of Health
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{2 000}	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		

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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 #H5257008 and H5257009. As a result, the following correction orders are issued related to H5257008 and H5257009. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000		

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2 000	Continued From page 1 Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician 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 interview and document review, the facility failed to ensure one of three resident's,	2 900		

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2 900	Continued From page 2 (R1), reviewed received the necessary care to prevent pressure ulcers when staff failed to follow physician orders to assess the skin to R1's right lower extremity daily. R1 was harmed when she developed a stage II pressure ulcer on her right heel requiring hospitalization. The findings include: R1's medical record was reviewed. R1 had diagnoses that included recent fracture of the right tibia and fibula. R1's significant change minimum data set dated 1/1/2017 indicated R1 had moderate cognitive impairment. R1's care plan edited on 1/25/2017 indicated R1 had impaired mobility and that R1 needed assistance with two staff for activities of daily living. A physician order dated 1/9/2017 at 5:20 p.m. indicated R1 was to continue with the imobilizer controlled ankle movement (CAM) boot at all times (to the right lower extremity) but that staff were to remove the boot daily for skin checks. Skin check assessments for 1/9/2017 thru 1/19/2017 indicated all skin assessments to R1's right lower extremity were completed by staff and twice on four of the days during that time period. A braden scale assessment completed on 1/16/2017 indicated R1 was at high risk for skin breakdown. A wound care data form dated 1/18/2017 indicated R1 had a wound to the right heel that was assessed to be a stage II pressure ulcer and was 6.5 centimeters (cm) x 7.5 cm. The wound was described as purple/maroon in color, did not blanche, and was mushy with white skin falling off. The pressure ulcer was foul smelling. R1's	2 900		

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	00817	A. BUILDING: _____ B. WING _____	C 08/24/2017

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2 900	Continued From page 3 sock inside her CAM boot was wet, odorous, and was removed. A physician communication form dated 1/19/2017 indicated that facility staff noted two pressure areas on R1's right lower leg and heel, possibly from the air cast. Heel wound was 6.5 cm x 7.5 cm covered with eschar and had white peeling skin around the edges. A physician did come and see R1's wounds that day. A physician order dated 1/19/2017 instructed staff that R1 needed to see podiatry for debridement of heel ulcer. Further orders on 1/19/2017 at 5:45 p.m., instructed staff to transfer R1 to the emergency room per family request. Hospital discharge summary records indicate R1 was admitted to the hospital on 1/19/2017 with a diagnosis including decubitis ulcers involving R1's right lower extremity. R1 had a cast placed over her right heel with areas cut out for her ulcers to prevent further pressure injury to the heel. R1 was discharged back to the facility on 1/23/2017 A facility note on 1/23/2017 at 9:00 a.m., signed by the facility administrator, stated the administrator called R1's family member, (FM)-I. The administrator told FM-I that facility staff were not fully removing R1's CAM boot which would allow for a complete assessment of R1's skin to be completed. Facility staff were only performing CMS (circulation, motion, and sensation) assessments on R1's right lower extremity. The administrator acknowledged that this was not acceptable. The call ended on 1/23/17 at 9:10 a.m. R1's death worksheet, dated 2/24/17, indicated R1 passed away on 2/24/2017 from natural	2 900		

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2 900	Continued From page 4 causes related to chronic kidney disease, recurrent aspiration pneumonia, and congestive heart failure. When interviewed on 2/8/2017 at 9:25 a.m. the director of nursing (DON) stated R1 had physician orders for staff to remove R1's CAM boot daily and perform skin checks. The DON stated that the pressure ulcer was found on R1's right heel on 1/19/2017. The DON spoke with facility staff to see how R1's skin checks were being done and found out that staff were treating R1's CAM boot like a cast and were not removing to check R1's skin under the boot. Staff were not assessing R1's heel. When R1's wound was found on 1/19/2017 it was covered in black eschar, wounds were seen that day by R1's physician. The DON acknowledged that facility staff were charting that skin assessments were completed per physician orders from 1/9/2017 to 1/19/2017; however, that was not accurate. R1's right lower extremity skin was not assessed for 10 days, even though the physician orders indicated facility staff were to assess daily. When interviewed on 7/25/2017 at 2:45 p.m. FM-I stated that after admission to the hospital, R1 needed to have her right heel debrided. R1 had increased pain because of the ulcer and did not fully recover before passing away approximately one month later. FM-I stated that the facility administration admitted to FM-I that facility staff were not performing daily skin checks to R1's right lower extremity per physician orders. A facility policy titled, Skin - Prevention and Treatment of Breakdown, dated 3/1/2010, provided staff with guidelines for prevention and treatment of skin problems. Measures for prevention of skin breakdown include daily	2 900		

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2 900	Continued From page 5 inspection of a resident's skin, and for staff to report early signs of skin breakdown. Resident skin and clothing should be kept clean and dry. SUGGESTED METHOD OF CORRECTION: The facility administrator, or designee could review the current policy and procedure for pressure ulcers, and could provide education to staff on pressure ulcers. The administrator, or designee, could educate staff on the importance of following physician orders. The administrator or designee could provide monitoring for compliance and treatment. TIME PERIOD TO CORRECT: Twenty-one (21) 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	21850		

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21850	Continued From page 6 by: Based on interview and document review, the facility failed to ensure one of three resident's, (R1), reviewed was free from maltreament when facility staff neglected R1 and failed to provide the necessary care to prevent pressure ulcers. Facility staff failed to follow physician orders to assess the skin to R1's right lower extremity daily. R1 was harmed when she developed a stage II pressure ulcer on her right heel requiring hospitalization. Based on interview and document review, the facility failed to ensure one of three resident's, (R1), reviewed received the necessary care to prevent pressure ulcers when staff failed to follow physician orders to assess the skin to R1's right lower extremity daily. R1 was harmed when she developed a stage II pressure ulcer on her right heel requiring hospitalization. The findings include: R1's medical record was reviewed. R1 had diagnoses that included recent fracture of right tibia and fibula. R1's significant change minimum data set dated 1/1/2017 indicated R1 had moderate cognitive impairment. R1's care plan edited on 1/25/2017 indicated R1 had impaired mobility and that R1 needed assistance with two staff for activities of daily living. A physician order dated 1/9/2017 at 5:20 p.m. indicated R1 was to continue with the imobilizer controlled ankle movement (CAM) boot at all times (to right lower extremity) but that staff were to remove the boot daily for skin checks. Skin check assessments for 1/9/2017 thru 1/19/2017 indicated all skin assessments were	21850		

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21850	Continued From page 7 completed by staff and twice on four of the days during that time period. Braden scale assessment completed on 1/16/2017 indicated R1 was at high risk for skin breakdown. Wound care data form dated 1/18/2017 indicated R1 had a wound to right heel that was assessed to be a stage II pressure area and was 6.5 centimeters (cm) x 7.5 cm, was foul smelling, and beefy red. R1's sock inside her CAM boot was wet, stinky, and was removed. The wound was described as purple/maroon in color, did not blanche, and was mushy with white skin falling off. A physician communication form dated 1/19/2017 indicated that facility staff noted two pressure areas on R1's right lower leg and heel, possibly from the air cast. Heel wound was 6.5 cm x 7.5 cm covered with eschar and had white peeling skin around the edges. A physician did come and see R1's wounds that day. A physician order dated 1/19/2017 instructed staff that R1 needed to see podiatry for debridement of heel ulcer. Further orders on 1/19/2017 at 5:45 p.m., instructed staff to transfer R1 to the emergency room per family request. Hospital records indicate R1 was admitted to the hospital on 1/19/2017 with a diagnosis including decubitis ulcers involving R1's right lower extremity. R1 was discharged back to the facility on 1/23/2017 A facility internal investigation dated 1/23/2017 at 9:00 a.m. stated the facility administrator called R1's family member, (FM)-I. The administrator	21850		

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21850	Continued From page 8 told FM-I that facility staff were not fully removing R1's CAM boot which would allow for a complete assessment of R1's skin to be completed. Facility staff were only performing CMS (circulation, motion, and sensation) assessments on R1's right lower extremity. The administrator acknowledged that this was not acceptable. When interviewed on 2/8/2017 at 9:25 a.m. the director of nursing (DON) stated R1 had orders for staff to remove R1's CAM boot daily and perform skin checks. The DON stated that skin areas were found on R1 on 1/19/2017. The DON spoke with facility staff to see how R1's skin checks were being done and found out that staff were treating R1's CAM boot like a cast and were not removing to check R1's skin under the boot. Staff were not assessing R1's heel. When R1's wound was found on 1/19/2017 it was covered in black eschar, wounds were seen that day by R1's physician. The DON acknowledged that facility staff were charting that skin assessments were completed per physician orders from 1/9/2017 to 1/19/2017; however, that was not accurate. When interviewed on 7/25/2017 at 2:45 p.m. FM-I stated that after admission to the hospital, R1 needed to have her right heel debrided. R1 had increased pain because of the ulcer and did not fully recover before passing away approximately one month later. FM-I stated that the facility administration admitted to FM-I that facility staff were not performing daily skin checks to R1's right lower extremity per physician orders. A facility policy titled, Skin - Prevention and Treatment of Breakdown, dated 3/1/2010, provided staff with guidelines for prevention and treatment of skin problems. Measures for prevention of skin breakdown include daily	21850		

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21850	Continued From page 9 inspection of a resident's skin, and for staff to report early signs of skin breakdown. Resident skin and clothing should be kept clean and dry. SUGGESTED METHOD OF CORRECTION: The facility administrator or designee could educate involved staff on the importance of following the current policy and procedure for pressure ulcers, and on the importance of following physician orders. The administrator or designee could educate staff on the abuse/neglect prevention policy and procedure and audit staff compliance regarding staff response to following facility policy and physician orders. The DON could report the findings to the quality assurance committee. TIME PERIOD TO CORRECT: Twenty-one (21) days	21850		