# DEPARTMENT OF HEALTH

# Office of Health Facility Complaints Investigative Report PUBLIC

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

- **x** Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- **X** State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- X 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):									
n:									
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## **Mitigating Factors:**

The "mitigating factors"	n Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was					
determined that the 🗌 Ir	dividual(s) and/or 🛛 Facility is responsible for the					
$\Box$ Abuse $\boxtimes$ N	eglect 🔲 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.						
substantiated against an i possible inclusion of the	l be notified of their right to appeal the maltreatment finding. If the maltreatment is dentified employee, this report will be submitted to the nurse aide registry for finding on the abuse registry and/or to the Minnesota Department of Human Services on in accordance with the provisions of the background study requirements under					

**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	$\bigcirc$ N/A
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Specify:

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

● Yes ○ No ○ N/A

Spe	cify:
Inte	rviews: The following interviews were conducted during the investigation: rview with reporter(s)
lf u	able to contact reporter, attempts were made on:
Dat	e: Time: Date: Time: Date: Time:
	rview with family: • Yes O No O N/A Specify: you interview the resident(s) identified in allegation: res O No O N/A Specify:
-	you interview additional residents? • Yes
	I number of resident interviews: Three
	rview with staff: • Yes $\bigcirc$ No $\bigcirc$ N/A Specify:
Ten Tot Phy Nur Phy Inte	nessen Warning given as required:  Yes No al number of staff interviews: Eight sician Interviewed: Yes No se Practitioner Interviewed: Yes No sician Assistant Interviewed: Yes No rview with Alleged Perpetrator(s): Yes No N/A Specify:
Dat	
We	able to contact was subpoena issued: O Yes, date subpoena was issued O No e contacts made with any of the following: Emergency Personnel O Police Officers O Medical Examiner O Other: Specify ervations were conducted related to: Wound Care Personal Care Cleanliness
Wa	any involved equipment inspected: 🔿 Yes 🛛 🔿 No 💿 N/A

Was equipment being operated in sa	fe manne	r: 🔿 Yes	$\bigcirc$ Ne	⊙	
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

		AND HUMAN SERVICES				FORM	: 10/17/2017 APPROVED . 0938-0391	
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ·		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	245257		B. WING	)	· · · · · · · · · · · · · · · · · · ·		}-C ∕ <b>16/2017</b>	
NAME OF I	NAME OF PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	10/2011	
ST ОТТС	S CARE CENTER				920 SOUTHEAST 4TH STREET LITTLE FALLS, MN 56345			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMEN	TS	{F 0	00]	}			
	completed, to follow related to complain St. Otto's Care Cen CFR Part 483, subp Term Care Facilities The facility is enroll signature is not req page of the CMS-28 correction is require	A Revisit (PCR) was wup on deficiencies issued t H5257008 and H5257009. Inter is in compliance with 42 part B, requirements for Long s. ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of the electronic documents.						
ABORATORY	DIRECTOR'S OR PROVIDI	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO.</u>	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
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	ST OTTOS CARE CENTER			920 SOUTHEAST 4TH STREET		
51 0110	S CARE CENTER			LITTLE FALLS, MN 56345		
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F 000	INITIAL COMMENT	ſS	FC	000		
F 314 SS=G	to investigate case As a result, the follor related to H525700 is enrolled in ePOC not required at the CMS-2567 form. E POC will be used a 483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure (i) A resident receive professional standa pressure ulcers and ulcers unless the in demonstrates that (ii) A resident with p necessary treatment professional standa healing, prevent inf from developing. This REQUIREMED by: Based on interview facility failed to ens (R1), reviewed rece prevent pressure u physician orders to	RESSURE SORES . Based on the sessment of a resident, the	F٤	314		
		Il pressure ulcer on her right				(X6) DATE
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		WU DAIL

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.

ORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/08/2017

FORM APPROVED

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391		
STATEMENT	STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245257					C 08/24/2017			
	PROVIDER OR SUPPLIER			92	TREET ADDRESS, CITY, STATE, ZIP CODE 20 SOUTHEAST 4TH STREET ITTLE FALLS, MN 56345				
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F 314	heel requiring hosp The findings includ R1's medical record diagnoses that inclu- right tibia and fibula minimum data set of had moderate cogr plan edited on 1/25 impaired mobility a with two staff for ac A physician order d indicated R1 was to controlled ankle mo- times (to the right la were to remove the Skin check assess 1/19/2017 indicated right lower extremit twice on four of the A braden scale ass 1/16/2017 indicated breakdown. A wound care data indicated R1 had a was assessed to b was 6.5 centimeter was described as p blanche, and was r off. The pressure of sock inside her CA was removed.	italization.	F3	14					

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 5

PRINTED: 09/08/2017

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F 314	indicated that facilit areas on R1's right from the air cast. If cm covered with es- skin around the ed- see R1's wounds the A physician order of that R1 needed to a heel ulcer. Further p.m., instructed sta emergency room p Hospital discharge was admitted to the diagnosis including right lower extremit her right heel with a prevent further pre- was discharged ba A facility note on 1/ by the facility admin administrator called The administrator to not fully removing a allow for a completed be completed. Face CMS (circulation, r assessments on R administrator ackn acceptable. The c a.m. R1's death worksh R1 passed away o causes related to c	by staff noted two pressure lower leg and heel, possibly leel wound was 6.5 cm x 7.5 schar and had white peeling ges. A physician did come and hat day. lated 1/19/2017 instructed staff see podiatry for debridement of orders on 1/19/2017 at 5:45 iff to transfer R1 to the		314			

FORM CMS-2567(02-99) Previous Versions Obsolete

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
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		245257	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	08/2	24/2017
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st отто	S CARE CENTER				LITTLE FALLS, MN 56345		
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ind					DEFICIENCY)		
	_						
F 314	Continued From pa	ige 3	F3	314			
	When interviewed (	on 2/8/2017 at 9:25 a.m. the					
	director of nursing	(DON) stated R1 had					
	physician orders fo	r staff to remove R1's CAM					
		orm skin checks. The DON sure ulcer was found on R1's					
		017. The DON spoke with					
	facility staff to see I	now R1's skin checks were					
		Ind out that staff were treating					
		a cast and were not removing under the boot. Staff were not					
		el. When R1's wound was					
		it was covered in black					
		ere seen that day by R1's					
		N acknowledged that facility that skin assessments were					
		sician orders from 1/9/2017 to					
	1/19/2017; howeve	r, that was not accurate. R1's					
		ty skin was not assessed for 10					
	facility staff were to	the physician orders indicated					
	•						
	When interviewed	on 7/25/2017 at 2:45 p.m. FM-I					
	stated that after ad	mission to the hospital, R1 r right heel debrided. R1 had					
	increased pain bec	ause of the ulcer and did not					
	fully recover before	e passing away approximately					
		M-I stated that the facility					
		nitted to FM-I that facility staff g daily skin checks to R1's					
		ty per physician orders.					
		d, Skin - Prevention and					
		kdown, dated 3/1/2010, guidelines for prevention and					
		roblems. Measures for					
	prevention of skin	breakdown include daily					
		ident's skin, and for staff to					
1	report early signs (	of skin breakdown. Resident	1				

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If continuation sheet Page 4 of 5

PRINTED: 09/08/2017

		I AND HUMAN SERVICES			O		VPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION			LETED
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F 314	Continued From pa skin and clothing s	age 4 hould be kept clean and dry.	F	314			

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00817

PRINTED: 09/08/2017

Minnesc	ota Department of He	ealth			T OF IW	AFFNUVED
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ST OTTO	OS CARE CENTER		THEAST 4TH			
			ALLS, MN 50			1
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{2 000}	Initial Comments		{2 000}			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall with a schedule of f the Minnesota Depa Determination of will corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department wit	hearing on any assessments n non-compliance with these a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	follow up on correct complaint H525700	TS: llow up was completed, to tion orders issued related to 8 and H5257009. St. Otto's ound in compliance with state				
	epartment of Health					

OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00817	B. WING		R-	·C <b>6/2017</b>
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07.0770			HEAST 4TH			
	S CARE CENTER		ALLS, MN 5			
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	The facility is enroll	ed in ePOC and therefore a				
		uired at the bottom of the first				
	page of state form.	Although no plan of correction				
	is required, it is requ	uired that the facility				
	acknowledge receip	ot of the electronic documents.				
					2	
Minnesota De	partment of Health				en e	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	OF CONNECTION		A. BUILDING: _			
		00817	B. WING		C 08/24/2017	
IAME OF F	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	TATE, ZIP CODE		
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	La construction de la constructi		ALLS, MN 56			1
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2 000	Initial Comments		2 000			
	*****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall	Minnesota Statute, section ction order has been issued ey. If, upon reinspection, it is siency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Re When a rule contai comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. ns several items, failure to the items will be considered . Lack of compliance upon any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	investigate compla As a result, the foll issued related to H facility has agreed	gation was conducted to int #H5257008 and H5257009 owing correction orders are 5257008 and H5257009. The to participate in the electronic ensure orders consistent with				

		alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _			C
		00817	B. WING		08/24/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
т отто	S CARE CENTER		ITHEAST 4TH S FALLS, MN 563			
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2 000	Continued From pa	ige 1	2 000			
2 900	http://www.health.s obul.htm The State delineated on the a Department of Hea electronically. Altho necessary for State the word "corrected Then indicate in the process, under the date your orders wi electronically subm Department of Hea	Ith orders being submitted ough no plan of correction is Statutes/Rules, please enter " in the box available for text. e electronic State licensure heading completion date, the ill be corrected prior to itting to the Minnesota				
	comprehensive res of nursing services development of a r provides that: A. a resident wh without pressure s pressure sores unl condition demonstr authenticates, that B. a resident w receives necessar	sores. Based on the sident assessment, the directo must coordinate the nursing care plan which no enters the nursing home cores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and who has pressure sores by treatment and services to revent infection, and prevent veloping.			·	
	by: Based on interview	ent is not met as evidenced and document review, the sure one of three resident's,				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	or ophile then					
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2 900	Continued From pa	age 2	2 900	unanderen offensen offensen		
	prevent pressure u physician orders to lower extremity dai developed a stage heel requiring hosp					
	diagnoses that incl right tibia and fibul minimum data set had moderate cog plan edited on 1/25 impaired mobility a	le: rd was reviewed. R1 had luded recent fracture of the a. R1's significant change dated 1/1/2017 indicated R1 nitive impairment. R1's care 5/2017 indicated R1 had and that R1 needed assistance ctivities of daily living.				
	indicated R1 was t controlled ankle m times (to the right were to remove the	dated 1/9/2017 at 5:20 p.m. o continue with the imobilizer ovement (CAM) boot at all lower extremity) but that staff e boot daily for skin checks.				
	right lower extremi	d all skin assessments to R1's ity were completed by staff and e days during that time period.				
		sessment completed on d R1 was at high risk for skin				
	indicated R1 had a was assessed to b was 6.5 centimete was described as blanche, and was	a form dated 1/18/2017 a wound to the right heel that be a stage II pressure ulcer and ers (cm) x 7.5 cm. The wound purple/maroon in color, did not mushy with white skin falling ulcer was foul smelling. R1's				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _			C
		00817	B. WING			24/2017
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
т отто	S CARE CENTER		THEAST 4TH			
		ATEMENT OF DEFICIENCIES	FALLS, MN 56	PROVIDER'S PLAN O	F CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	COMPLET DATE
2 900	Continued From pa	age 3	2 900			
	sock inside her CA was removed.	M boot was wet, odorous, and				
	indicated that facili areas on R1's right from the air cast. I cm covered with es	unication form dated 1/19/2017 ty staff noted two pressure t lower leg and heel, possibly Heel wound was 6.5 cm x 7.5 schar and had white peeling ges. A physician did come and hat day.				
	that R1 needed to heel ulcer. Further	dated 1/19/2017 instructed staf see podiatry for debridement or r orders on 1/19/2017 at 5:45 aff to transfer R1 to the per family request.				
	was admitted to th diagnosis including right lower extremi her right heel with prevent further pre	e summary records indicate R1 e hospital on 1/19/2017 with a g decubitis ulcers involving R1' ity. R1 had a cast placed over areas cut out for her ulcers to essure injury to the heel. R1 ack to the facility on 1/23/2017				
	by the facility admi administrator calle The administrator not fully removing allow for a comple be completed. Fa CMS (circulation, assessments on F administrator ackr	/23/2017 at 9:00 a.m., signed inistrator, stated the ed R1's family member, (FM)-I. told FM-I that facility staff were R1's CAM boot which would te assessment of R1's skin to cility staff were only performing motion, and sensation) R1's right lower extremity. The nowledged that this was not call ended on 1/23/17 at 9:10				
		neet, dated 2/24/17, indicated on 2/24/2017 from natural				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
ND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _				
		00817	B. WING			C 08/24/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
от отто	S CARE CENTER		THEAST 4TH S ALLS, MN 563				
(X4) ID	SUMMABY STA			PROVIDER'S PLAN O	F CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	) THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 4	2 900				
	causes related to chronic kidney disease, recurrent aspiration pneumonia, and congestive heart failure.						
	director of nursing physician orders for boot daily and perfe- stated that the pres- right heel on 1/19/2 facility staff to see being done and for R1's CAM boot like to check R1's skin assessing R1's heer found on 1/19/2017 eschar, wounds we physician. The DC staff were charting completed per phy 1/19/2017; however right lower extremi	on 2/8/2017 at 9:25 a.m. the (DON) stated R1 had r staff to remove R1's CAM orm skin checks. The DON soure ulcer was found on R1's 2017. The DON spoke with how R1's skin checks were and out that staff were treating a cast and were not removing under the boot. Staff were not el. When R1's wound was 7 it was covered in black ere seen that day by R1's DN acknowledged that facility that skin assessments were sician orders from 1/9/2017 to er, that was not accurate. R1's ty skin was not assessed for 10 the physician orders indicated D assess daily.					
	When interviewed stated that after ac needed to have he increased pain beo fully recover before one month later. F administration adm were not performin right lower extremi A facility policy title Treatment of Brea	on 7/25/2017 at 2:45 p.m. FM- Imission to the hospital, R1 or right heel debrided. R1 had cause of the ulcer and did not e passing away approximately FM-I stated that the facility nitted to FM-I that facility staff ng daily skin checks to R1's ty per physician orders. ed, Skin - Prevention and kdown, dated 3/1/2010, guidelines for prevention and					

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	DENTIFICATION NOMBER.	A. BUILDING:			
		00817	B. WING		C 08/24/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE		
отто та	S CARE CENTER		THEAST 4TH FALLS, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	nge 5	2 900	anna tha an tha th	en a chunne a chunne an	
	report early signs o	dent's skin, and for staff to f skin breakdown. Resident hould be kept clean and dry.				
	facility administrate current policy and p and could provide o ulcers. The admini- educate staff on th physician orders.	THOD OF CORRECTION: The or, or designee could review the procedure for pressure ulcers, education to staff on pressure strator, or designee, could e importance of following The administrator or designee itoring for compliance and	Э			
	TIME PERIOD TO days	CORRECT: Twenty-one (21)				
21850	Residents of HC F Subd. 14. Freed Residents shall be defined in the Vuln "Maltreatment" me section 626.5572, intentional and nor physical pain or inj conduct intended t distress. Every res non-therapeutic ch except in fully docu authorized in writin resident's physicia period of time, and	4.651 Subd. 14 Patients & ac.Bill of Rights om from maltreatment. free from maltreatment as erable Adults Protection Act. ans conduct described in subdivision 15, or the n-therapeutic infliction of ury, or any persistent course of o produce mental or emotional sident shall also be free from nemical and physical restraints umented emergencies, or as og after examination by a n for a specified and limited I only when necessary to at from self-injury or injury to	1			
	This MN Requirem	nent is not met as evidenced				

Minneso	ta Department of He	ealth			<b></b>	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	E CONSTRUCTION	(X3) DATE COMP	
		00817	B. WING		08/2	) 4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	S CARE CENTER		HEAST 4TH			
510110			ALLS, MN 50			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	Continued From pa	age 6	21850			
	facility failed to ens (R1), reviewed was facility staff neglect necessary care to p Facility staff failed to assess the skin to R1 was harmed wh pressure ulcer on h hospitalization. Based on interview facility failed to ens (R1), reviewed reco prevent pressure u physician orders to lower extremity dai	and document review, the sure one of three resident's, a free from maltreament when ted R1 and failed to provide the prevent pressure ulcers. to follow physician orders to R1's right lower extremity daily. Then she developed a stage II her right heel requiring and document review, the sure one of three resident's, eived the necessary care to locers when staff failed to follow assess the skin to R1's right IV. R1 was harmed when she II pressure ulcer on her right pitalization.				
	The findings includ	e:				
	diagnoses that incl tibia and fibula. R1 data set dated 1/1/ moderate cognitive edited on 1/25/201	d was reviewed. R1 had uded recent fracture of right 's significant change minimum '2017 indicated R1 had e impairment. R1's care plan 7 indicated R1 had impaired 1 needed assistance with two of daily living.				
	indicated R1 was t controlled ankle m times (to right lowe	dated 1/9/2017 at 5:20 p.m. o continue with the imobilizer ovement (CAM) boot at all er extremity) but that staff were t daily for skin checks.				
Minnosota		ments for 1/9/2017 thru d all skin assessments were				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
					С		
		00817	B. WING		08/	08/24/2017	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
st оттс	S CARE CENTER		THEAST 4TH : ALLS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21850	Continued From pa	age 7	21850	<u> </u>			
	completed by staff and twice on four of the days during that time period.						
	Braden scale asse 1/16/2017 indicated breakdown.	ssment completed on d R1 was at high risk for skin					
	R1 had a wound to to be a stage II pre centimeters (cm) x beefy red. R1's so wet, stinky, and wa described as purple	orm dated 1/18/2017 indicated right heel that was assessed ssure area and was 6.5 7.5 cm, was foul smelling, and ck inside her CAM boot was is removed. The wound was e/maroon in color, did not mushy with white skin falling					
	indicated that facili areas on R1's right from the air cast. I cm covered with es	unication form dated 1/19/2017 ty staff noted two pressure t lower leg and heel, possibly Heel wound was 6.5 cm x 7.5 schar and had white peeling ges. A physician did come and hat day.					
	that R1 needed to heel ulcer. Further	dated 1/19/2017 instructed staf see podiatry for debridement o r orders on 1/19/2017 at 5:45 aff to transfer R1 to the per family request.					
	hospital on 1/19/20 decubitis ulcers inv	dicate R1 was admitted to the 017 with a diagnosis including volving R1's right lower discharged back to the facility					
	9:00 a.m. stated th	vestigation dated 1/23/2017 at le facility administrator called er, (FM)-I. The administrator					

STATEMEN	ta Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _		с		
		00817	B. WING			08/24/2017	
IAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE			
отто тто	S CARE CENTER		THEAST 4TH 3 ALLS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21850	Continued From pa	age 8	21850				
	told FM-I that facili R1's CAM boot wh assessment of R1 Facility staff were of (circulation, motion on R1's right lower acknowledged that When interviewed director of nursing for staff to remove perform skin check areas were found of spoke with facility checks were being were treating R1's not removing to ch Staff were not asse wound was found of black eschar, wour physician. The DO staff were charting completed per phy 1/19/2017; howeve When interviewed stated that after ac needed to have he increased pain bee fully recover before one month later. F administration adn were not performin right lower extremi A facility policy title Treatment of Brea	ty staff were not fully removing ich would allow for a complete 's skin to be completed. only performing CMS n, and sensation) assessments 'extremity. The administrator it this was not acceptable. on 2/8/2017 at 9:25 a.m. the (DON) stated R1 had orders R1's CAM boot daily and ks. The DON stated that skin on R1 on 1/19/2017. The DON staff to see how R1's skin done and found out that staff CAM boot like a cast and were teck R1's skin under the boot. essing R1's heel. When R1's on 1/19/2017 it was covered in nds were seen that day by R1's DN acknowledged that facility that skin assessments were sician orders from 1/9/2017 to er, that was not accurate. on 7/25/2017 at 2:45 p.m. FM-I dmission to the hospital, R1 er right heel debrided. R1 had cause of the ulcer and did not e passing away approximately FM-I stated that the facility thitted to FM-I that facility staff ing daily skin checks to R1's ity per physician orders.					
	treatment of skin p	guidelines for prevention and problems. Measures for breakdown include daily					

STATE FORM

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00817	B. WING		C 08/24/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADI		DRESS, CITY, S	STATE, ZIP CODE			
ST OTTOS CARE CENTER 920 SOUTHE						
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	OULD BE COMPLETE	
21850	Continued From page 9		21850			
	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 MET The facility adminis educate involved st following the curren pressure ulcers, an following physician designee could edu abuse/neglect preve and audit staff com response to followir orders. The DON co quality assurance c	HOD OF CORRECTION: trator or designee could aff on the importance of it policy and procedure for d on the importance of orders. The administrator or icate staff on the ention policy and procedure pliance regarding staff ng facility policy and physician pould report the findings to the				
Ainnesota Department of Health						