MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Golden Livingcenter Meadow Lane
2209 Utah Avenue
Benson, MN 56215
Swift County

Report #: H5313022

Date: January 27, 2015

Date of Visit: October 13 and 14, 2014
Time of Visit: 11:30 a.m.-4:00 p.m. and
8:30 a.m.-1:00 p.m.

By: Jolene Bertelsen, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a resident was neglected when the resident came to the hospital appearing malnourished and dehydrated with severe dry skin and multiple open sores on his/her buttocks.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☐ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect is substantiated. The resident developed cold-like symptoms and continued to decline at the facility. Staff monitored the resident, but did not notify the physician when the resident's condition worsened. In addition, upon admission to the hospital, the resident was noted to have multiple areas of skin breakdown.

The resident had diagnoses including dementia. The resident was alert but disoriented to person, place and time. The morning prior to hospitalization, nurses' notes document the resident had a temperature of 102.3 F, oxygen saturations were 82% on room air and dyspnea with breathing. The nurse applied a cold cloth to the forehead, administered Tylenol and applied oxygen at 2 liters per minute. At 11:14 a.m., the resident's temperature dropped to 100.0 F, breathing was non-labored, but the resident continued to have a cough. The note documented the resident had been sleepy for the last couple of days with a poor appetite and poor fluid intake. At 7:30 p.m., Tylenol was given for a temperature of 102.0 F. At 1:45 a.m., the resident's oxygen saturations were 85% and oxygen was increased to 3 liters. The oxygen saturations increased to the low 90's on the 3 liters of oxygen. The resident's temperature was 102.5 F. A Tylenol suppository was given and notes document the resident sounded less "rattly". At 5:36 a.m., the resident's temperature was 102.7 F and the resident was congested. The resident was suctioned and oxygen was increased to 4 liters for oxygen saturations in the upper 80's. At 6:00 a.m., the resident's temperature was 103.4 F, heart rate was 130, and respiratory rate was 40. The staff was unable to obtain a blood pressure and congestion and rhonchi sounds were noted, with oxygen saturations at 90% on 4 liters of oxygen. The resident was sent to the hospital at 6:30 a.m.

Hospital records document the patient was unresponsive upon arrival to the hospital. The admission vital signs included: temperature: 100.2 F, respiratory rate: 47 breaths per minute, blood pressure: 137/71 mm hg, oxygen saturation: 92 % with face mask oxygen at 15 liters per minute. The resident was diagnosed with left lower lobe pneumonia and acute pre-renal failure. The resident was noted to have "extremely poor" skin hygiene with extensive breakdown noted over the sacral area with evidence of skin loss and early muscle breakdown. Wound documentation revealed: a bruised and reddened area near the coccyx, the right buttock had multiple areas that appear to be friction tears all measuring 0.5 cm x 0.5 cm, the coccyx area had a stage 3 wound which measured 1.5 cm round, the right buttock had multiple eraser size, stage 2 open areas in a 10 cm long by 5 cm long area, All of the open areas have granulating wound beds. The left buttock has a 11 cm wide by 12.5 cm long area with a stage 2 ulcer with a 5.4 cm by 2.0 cm wide open area within that. There is a 3.2 cm long by 1.0 cm wide

stage 2 open area just distal to the 11 cm by 12.5 cm area on the left buttock. The resident died at the hospital four days after admission. The cause of death was pneumonia.

Staff interviews verified the family was notified when the resident experienced a decline in condition, but the physician was never notified of a change in condition. Several staff stated the resident was monitored and administered Tylenol for increased temperatures. The resident was suctioned and oxygen was placed for decreased saturations. Several staff stated the resident had a decreased appetite and decreased fluid intake over the 3 day period. Staff verified they were treating the resident for a temperature and monitoring the resident's respiratory status, but did not notify the physician when the resident experienced a decline in condition. Several staff stated they were unaware of any skin breakdown to the resident's buttocks or coccyx areas.

Physician (M) was interviewed and stated the resident arrived at the hospital with a 3 day history of cold-like symptoms, a temperature that ranged from 100.5 to 103.4 F for 3 days and little food or fluid intake for 3 days. The resident was unresponsive upon arrival, had no purposeful movement and was using accessory muscles to breathe. The resident was placed on oxygen via facemask at 15 liters per minute. Lung sounds were diminished with scattered crackles and inspiratory and expiratory wheezes. The resident was observed to have very poor hygiene and multiple open areas, including stage 2 and stage 3 sacral ulcers.

Physician (N) was interviewed and stated facility staff did not notify him/her of a decline in the resident's condition and Physician (N) would have expected to be notified days prior to hospitalization when the resident began to decline. Physician (N) stated facility staff is able to contact a physician 24 hours a day and can send a patient to the hospital emergently, if needed. Physician (N) was not aware of any skin concerns related to the resident.

The policy entitled: Notification of change in resident health status, not dated, identified the facility will consult the resident's physician, nurse practitioner or physician assistant and if known the resident's legal representative or an interested family member when there is: acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications....Nursing judgment is an integral part of the skilled care provided in the facility therefore, such judgment must be applied in a case-by-case basis in keeping with acceptable nursing practice.

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 failed to ensure staff followed the policy and procedures to notify the physician when there was a change in condition. Over a 3 day period the resident was monitored by multiple staff and the physician was not notified of a change of condition.

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 If no, specify: _____
(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 If no, specify: _____
(State licensing orders will be available on the MDH website.)

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.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

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.

The Investigation included the following:

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

☒ Medical Records

☒ Medication Administration Records

☒ Facility Incident Reports

☒ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☐ Therapy and/or Ancillary Services Records

☒ Skin Assessments

☒ Care Guide

☒ Treatment Sheets

☒ Physician Progress Notes

☒ Laboratory and X-ray Reports

☐ Social Service Notes

☐ Meal Intake Records

☐ Weight Records

☒ Assessments

☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☒ Death Certificate

☐ Police Report

Additional facility records:

☒ Resident/Family Council Minutes

☒ Staff Time Sheets, Schedules, etc.

☐ Personnel Records/Background Check, etc.

☒ Facility In-service Records

☐ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: They were residents who had recent hospitalizations.

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

○ Yes ◉ No ○ N/A Specify: The resident was deceased at the time of the investigation.

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: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: The resident was deceased at the time of the investigation.

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 10

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 13

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator was identified in the complaint.

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	☐ Medication Pass	☐ Meals
☒ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☒ Infection Control	☒ Cleanliness	☐ Injury
☒ Use of Equipment	☒ Transfers	☒ Incontinence
☒ Call Light	☐ Other: _____	

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: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
MN Board of Nursing
Swift County Medical Examiners
Benson City Police Department
Swift County Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245313	A. BUILDING _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

(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 An abbreviated standard survey was conducted to investigate complaint #H5313022. As a result, the following deficiencies were issued.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth on the survey report. Our Plan of Action is prepared and executed as a means to continuously improve the quality of care and to comply with all the applicable state and federal regulatory requirements.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Roberta Dillon | Executive Director | 12-29-2014

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to notify the physician of a change of condition for 1 of 3 residents (R1) who experienced a decline in condition. Findings include: R1's medical record was reviewed and identified R1 had diagnoses that included dementia. He was alert but disoriented to person, place and time and may may respond to yes/no questions, but may not respond appropriately. On 9/28/14 (the day prior to hospitalization) nurse's notes indicated: 7:00 a.m. temperature: 102.3 F, oxygen saturation: 82% on room air, with signs and symptoms of dyspnea with breathing, respiratory rate: 24. Lung sounds were difficult to auscultate. The nurse applied a cold cloth to the forehead, administered Tylenol, and applied oxygen at 2 liters per minute. Oxygen saturation increased to 92% and breathing was noted to be non-labored. Robitussin was given for a cough. 11:14 a.m. Change of Condition: the resident had been sleepy for the last couple of days with poor appetite and poor fluid intake. Applied cold cloth to forehead, Tylenol administered, and oxygen at 2 liters applied. Temp dropped to 100.0 F. Fluids offered and consumed 360 cc of liquids. Breathing is non-labored and respirations 18-20. Continues to have cough, Robitussin given. 7:30 p.m. Tylenol was given for a temperature of 102.0 F.	F 157	F157 1) Resident R1 is no longer in our facility. 2) Charts were pulled and nursing notes reviewed, records reviewed, and audits began internally. Clinical start up done daily which serves as a checklist to identify Change of Condition and ensure follow up has been completed. Provided our policy to nurses of change in health status. 3) Re-education to all nursing immediately and upon first shift worked since MDH visit. Initiated staff training on Interact 3 tool immediately and upon first shift worked since MDH visit. On 10-14-14 verbally and posted that when in question to send a resident to the hospital it is important to rely on nursing judgment. CNA training on when to notify the nurses implemented immediately. Periodic audits utilizing tool F157 notification of change audit. 4)Monitoring to ensure compliance will be completed by the DNS/Designee through random weekly audits of notification of change policy is being utilized. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	1-4-2015

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On 9/29/14 (the day of hospitalization) nursing notes on 9/29/14 indicated:

1:45 a.m.: oxygen saturation: 85%, saturations increased to the low 90's on 3 liters of oxygen, T 102.5 F, Tylenol suppository given, sounds less "ratlly". 5:36 a.m.: temperature: 102.7 F continues congested, suctioned creamy mucus, oxygen increased to 4 liters, oxygen saturation in the upper 80's. 6:00 a.m., temperature: 103.4 F, heart rate: 130, RR 40. Unable to obtain a blood pressure, congestion and rhonchi sounds noted. Oxygen saturations: 90% on 4 liters of oxygen. Family would like resident to be seen as soon as possible. Resident was sent to the hospital at 6:30 a.m.

Hospital records dated 9/29/14 at 6:43 a.m., indicated the resident was unresponsive upon arrival to the hospital. The initial vital signs included: temperature: 100.2 F, respiratory rate: 47 breaths per minute, blood pressure: 137/71 mm hg, oxygen saturation: 92 % with face mask oxygen at 15 liters per minute. The resident was diagnosed with left lower lobe pneumonia and acute pre-renal failure. He also had extensive breakdown over the sacral area with evidence of skin loss and early muscle breakdown.

Registered Nurse (RN)-K was interviewed on 11/7/14 at 11:12 a.m. and stated R1 was monitored, and given Tylenol for increased temperatures over a three day period. RN (K) stated the night prior to hospitalization, R1 was sleepy, and did not "wake up" with cares. R1 was congested, required nasal suctioning, and was treated with Tylenol for a temperature greater than 101.0 F. RN (K) stated the family was notified the day prior to hospitalization of R1's

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change of condition, but she was unaware if the physician had been notified. RN (K) verified she did not notify the physician of R1's decline in condition, and stated she was unaware of criteria for notifying the physician of a change of condition.

RN (C) was interviewed on 10/13/14 at 2:25 p.m. and stated on the morning of hospitalization; she came on shift, and went to assess R1. R1 was unresponsive, and had a temperature of 103.4 F, respiratory rate: 40, pulse: 130 beats per minute, and she was unable to obtain a blood pressure reading. Oxygen saturation was 90% on 4 liters of oxygen. RN (C) sent R1 to the hospital for evaluation and treatment. RN (C) was not aware R1 had any skin breakdown.

Physician (M) was interviewed on 11/11/14 at 4:45 p.m. and stated the resident arrived at the hospital with a three day history of cold symptoms, a temperature that ranged from 100.5 to 103.4 F for three days, and had little food or fluid intake for three days. The resident was unresponsive to verbal commands. Upon arrival to the emergency room, vital signs included: temperature: 100.2 F, heart rate: 133 beats per minute, respiratory rate: 37, and blood pressure: 137/71. The resident had no purposeful movement, and was using his accessory muscles to breathe. The resident had very poor hygiene, and multiple open areas, including stage 2/3 ulcers located in the sacral area.

Physician (N) was interviewed on 11/24/14 at 5:14 p.m. and verified that he was not notified of the resident 's change of condition and would have expected to be notified days prior to hospitalization. He was also not aware of any skin

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F 157	Continued From page 4 concerns regarding the resident and was not notified by staff of any skin breakdown. The policy entitled: Notification of change in resident health status, not dated, documents "the facility will consult the resident's physician, nurse practitioner or physician assistant and if known the resident's legal representative or an interested family member when there is: acute illness or a significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications....Nursing judgment is an integral part of the skilled care provided in the facility therefore, such judgment must be applied in a case-by-case basis in keeping with acceptable nursing practice.	F 157		
F 314 SS=D	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 interview and document review the facility failed to ensure 1 of 3 residents (R1) reviewed received the necessary care and treatment to prevent pressure ulcer formation and	F 314	314 1) Resident R1 is no longer in our facility. 2) Charts were pulled and nursing noted reviewed, records reviewed, auditing began internally. Reviewed policy on skin care identification and treatment PowerPoint presentation with all nursing staff. Re-education to all nursing staff immediately and upon first shift worked upon MDH visit. CNA training related to wound care and when to notify the nurse. Reintroduced our protocol on resident care for CNA assignment sheets and re-train nurses to update care sheets as needed. 3) Implement F314 Pressure Ulcer Skin Integrity Weekly Audits and random repositioning audits. 4)Monitoring to ensure compliance will be completed by the DNS/Designee through random weekly audits of direct care that repositioning is being provided per care plan. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	1-4-2015

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breakdown to the coccyx and buttocks region.

Findings include:

R1 had diagnoses that included dementia, was disoriented to person, place and time. R1 may respond to yes/no questions, but may not respond appropriately.

The admission Comprehensive Weekly Skin Assessment completed on 9/11/14 indicated R1 had a red groin and Calmo cream was applied. On 9/18/14, the assessment indicated the resident's skin was intact on his buttocks and perineum. No additional skin assessments were completed prior to hospitalization on 9/29/14.

R1 was admitted to the hospital on 9/29/14. The resident was noted to have extensive breakdown over the sacral area with evidence of skin loss and early muscle breakdown. Wound documentation revealed a bruised and reddened area near the coccyx, the right buttock had multiple areas that appeared to be friction tears all measuring 0.5 centimeters (cm) x 0.5 cm. The coccyx area had a stage 3 wound (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) which measured 1.5 cm round, the right buttock had multiple eraser size stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) open areas in a 10 cm long by 5 cm long area. All of the open areas had granulating wound beds. The left buttock had a 11 cm wide by 12.5 cm long area with a stage 2-5.4 cm by 2.0 cm wide open area

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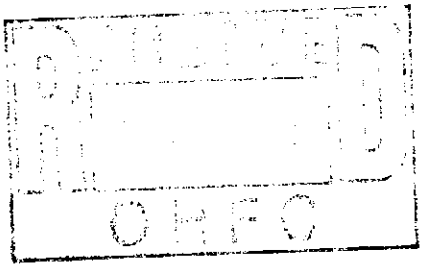
F 314	Continued From page 6	F 314		

within that. There was a 3.2 cm long by 1.0 cm wide stage 2 open area distal to the 11 cm by 12.5 cm area on the left buttock. The hospital contacted the nursing home and employee (C) told the hospital staff s/he was not aware of any open areas on the resident 's buttocks.

The care plan intervention, dated 9/23/14, documents the resident was at risk of pressure ulcer formation due to diabetes, limited mobility, a Braden score of 18 or less, and bowel incontinence. Several interventions included: observe for signs and symptoms of infection, provide thorough skin care after incontinent episode and apply barrier cream, and turn and reposition per assessment.

Registered nurse (RN)-C was interviewed on 10/13/14 at 2:25 p.m. and stated on the day of hospitalization, she did not receive report of any concerns regarding skin breakdown or pressure sores related to R1. RN-C stated staff will pass along in report any change of condition, or new skin concerns with the residents, and verified she did not receive a report of any skin breakdown with R1.

Licensed Practical Nurse (LPN)-J was interviewed on 11/7/14 at 2:37 p.m. and stated she worked with the resident the day prior to hospitalization and was aware of redness on the residents buttocks area, but was not aware of any open areas and was not updated by the nursing assistants of any open areas on the residents buttocks.



Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00930	A. BUILDING: _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

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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 #H5313022. As a result the following licensing order was issued.	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brooke Dillon — TITLE: Executive Director — (X6) DATE: 12/29/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1	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 interviews and documentation review the facility failed to ensure a resident (R1) received the necessary care and treatment to prevent the development of pressure sores. Findings include: The resident had diagnoses including dementia. He was alert but disoriented to person, place and time. The care plan documents the resident may respond to yes/no questions, but may not respond appropriately. The resident used the wheelchair for mobility, and required assistance from staff for eating and drinking. The admission Comprehensive Weekly Skin Assessment completed on 9/11/14 documents the resident had a red groin and Calmo cream was applied. On 9/18/14, the assessment documents the resident's skin was intact on his buttocks and perineum. No documentation that any additional assessments were completed prior to hospitalization was found. R1 was admitted to the hospital on 9/29/14. The resident was noted to have extensive breakdown over the sacral area with evidence of skin loss and early muscle breakdown. Wound documentation revealed a bruised and reddened	2 900		

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2 900	Continued From page 3	2 900		

area near the coccyx, the right buttock had multiple areas that appeared to be friction tears all measuring 0.5 centimeters (cm) x 0.5 cm. The coccyx area had a stage 3 wound (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.) which measured 1.5 cm round, the right buttock had multiple eraser size stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) open areas in a 10 cm long by 5 cm long area. All of the open areas had granulating wound beds. The left buttock had a 11 cm wide by 12.5 cm long area with a stage 2-5.4 cm by 2.0 cm wide open area within that. There was a 3.2 cm long by 1.0 cm wide stage 2 open area distal to the 11 cm by 12.5 cm area on the left buttock. The hospital contacted the nursing home and employee (C) told the hospital staff s/he was not aware of any open areas on the resident 's buttocks.

The care plan intervention, dated 9/23/14, documents the resident was at risk of pressure ulcer formation due to diabetes, limited mobility, a Braden score of 18 or less, and bowel incontinence. Several interventions included: observe for signs and symptoms of infection, provide thorough skin care after incontinent episode and apply barrier cream, and turn and reposition per assessment.

Registered nurse (RN)-C was interviewed on 10/13/14 at 2:25 p.m. and stated on the day of hospitalization, she did not receive report of any concerns regarding skin breakdown or pressure sores related to R1. RN-C stated staff will pass along in report any change of condition, or new

Minnesota Department of Health

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2 900	Continued From page 4 skin concerns with the residents, and verified she did not receive a report of any skin breakdown with R1. Licensed Practical Nurse (LPN)-J was interviewed on 11/7/14 at 2:37 p.m. and stated she worked with the resident the day prior to hospitalization and was aware of redness on the residents buttocks area, but was not aware of any open areas and was not updated by the nursing assistants of any open areas on the residents buttocks. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and re-educate staff on policies to ensure that all residents are assessed and provided necessary care and services to ensure pressure related skin conditions are monitored and treated accordingly. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty days (30).	2 900		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245313	A. Building B. Wing	1/16/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 12/29/2014	ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 12/29/2014	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	Date:	Signature of Surveyor:	Date:
	GA/KJ	1/26/2015	31591	1/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/25/2014				

AH Form Approved
1/26/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00930	A. Building B. Wing	1/16/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MEADOW LANE	2209 UTAH AVENUE BENSON, MN 56215

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	12/29/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/KJ	1/26/2015	31591	1/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/25/2014			