



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

Bethany Residence and Rehab Center
2309 Hayes Street Northeast
Minneapolis, MN 55418
Hennepin County

Report#: H5578019

Date: August 1, 2016

Date of Visit: August 28, 2015

By: Barbara White R.N., Special Investigator

Time of Visit: 8:30 a.m. – 4:45 p.m.

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

Facility Self Report Complaint

Allegation(s): **It is alleged** that a resident was neglected when staff failed to properly monitor and follow physician's orders for caring of the resident's wound. The resident is currently hospitalized for treatment of the wound.

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 Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
- 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 the preponderance of the evidence neglect did occur when staff failed to follow a physician's order for wound care. The staff did not complete the resident's wound care for four days. The wound became infected and the resident was hospitalized as a result of the infection.

The resident had diagnoses including venous insufficiency, and chronic stasis ulcer on the right ankle. The resident had lived at the facility for several years. The physician's order for care to the ulcer on the resident's ankle included daily application of Santyl (a medicated ointment) and to cover the wound with adhesive foam. A nurse did not change the dressing on 8/10/2015, 8/11/2015, and 8/12/2015, and on 8/14/2015 another nurse caring for the wound observed a foul odor, the skin was swollen and pink, and insects were observed in the wound. The resident was immediately sent to the hospital for care of the wound, the wound improved, and the resident returned to the facility.

The nurse that had not changed the dressing was interviewed and said she did not change the dressing and thought the order was to check that the dressing was in place instead of changing the dressing. When the error was discovered, the facility re-educated the nurse.

The resident was interviewed and stated his/her foot was okay and that s/he enjoyed living at the facility and felt the nurses took care of his/her wound. The family said in an interview that the facility had taken responsibility for the error and that the wound care had improved.

The physician, a wound care physician specialist, was interviewed, he noted that the resident's wound was chronic and had been slow to heal. He stated that the error of not changing the dressing for 3 days would have been significant in developing an infection.

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 related to implementing physician's orders and wound care and staff were educated on these policies. The facility utilized an electronic process for implementing treatments and the documentation related to the wound care was not clearly written and it was difficult to understand and follow.

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):

A post certification revisit was conducted to follow up on violations issued related to the complaint. The facility was found back in compliance on October 19, 2015.

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.

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:**

- | | |
|---|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input type="checkbox"/> Medication Administration Records | <input checked="" type="checkbox"/> Treatment Sheets |
| <input checked="" type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input type="checkbox"/> Social Service Notes |
| <input checked="" type="checkbox"/> Nurses Notes | <input type="checkbox"/> Meal Intake Records |
| <input type="checkbox"/> Activities Reports | <input type="checkbox"/> Weight Records |

Therapy and/or Ancillary Services Records

Assessments

Skin Assessments

Care Plan Records

Service Plan

Other, specify: _____

Other pertinent medical records:

Hospital Records

Ambulance/Paramedics

Medical Examiner Records

Death Certificate

Police Report

Other, specify: _____

Additional facility records:

Resident/Family Council Minutes

Personnel Records/Background Check, etc.

Staff Time Sheets, Schedules, 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: _____

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

Yes No N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): Yes No N/A Specify: _____

If unable to contact complainant, attempts were made on:

Date/time: _____ Date/time: _____ Date/time: _____

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

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: 7

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

Tennessee Warning given as required: Yes No

Total number of staff interviews: 10

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 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 Specify: _____

Was equipment being operated in safe manner: Yes No N/A Specify: _____

Were photographs taken: Yes No Specify: _____

- xc: Health Regulation Division - Licensing & Certification
- Minnesota Board of Examiners for Nursing Home Administrators
- Minnesota Board of Nursing
- The Office of Ombudsman for Long-Term Care
- Minneapolis City Police Department
- Hennepin County Attorney
- Minneapolis City Attorney

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

PRINTED: 09/17/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245578 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 09/14/2015 |
| NAME OF PROVIDER OR SUPPLIER BETHANY RESIDENCE AND REHABILITATION CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 | | |
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| F 000 | INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5578019. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. | F 000 | | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide dressing changes, and failed to maintain a dressing on the dialysis catheter for 1 of 1 residents (R1) reviewed for non pressure related wounds. This resulted in harm for R1 when the leg wound became infected and painful, and R1 required hospitalization. Findings include: R1 medical record was reviewed. R1 had a diagnosis of chronic kidney disease, dementia and venous insufficiency. The plan of care dated | F 309 | | | |

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 309 | <p>Continued From page 1</p> <p>2/19/13 noted R1 received hemodialysis 3 times a week, had a central venous catheter (CVC) in the upper chest which was to be covered with a dry dressing. The care plan directed staff to observe for signs of infection and bleeding at the catheter site. The care plan dated 2/20/13 noted R1 needed assist of one staff for transfers, dressing, bathing and grooming.</p> <p>The physician's note dated 8/3/15 documented that R1 had a venous wound on the right middle leg that had been open for 141 days, had light serous (light colored or clear) drainage, and no pain. The wound measured 3.6 c.m. by 2.6 c.m. with a depth of 0.2 c.m. On 8/3/15, the physician ordered Santyl ointment (An enzymatic debriding ointment, that works by breaking down dead skin.) daily to the wound and cover with adhesive foam.</p> <p>On 8/13/15 the nurse noted on the weekly skin checklist, that the wound bed was dark red with inflamed tissue surrounding and a foul odor.</p> <p>RN-H was interviewed on 9/3/15 at 1:40 p.m. and said the dressing removed on 8/13/15 had the date '8/9/15' written on it, and was the same dressing she had applied on Sunday, 8/9/15. RN-H reported the error to the Director of Nursing (DON). RN-H stated the dressing was changed on 8/14/15, when the dressing was removed there were several white crawling bugs in the wound and under the scabbed areas on the side of the wound. RN-H stated she covered the wound and sent R1 to the hospital.</p> <p>The hospital discharge summary dated 8/20/15 noted admission diagnoses of right lower extremity pain of the chronic venous ulcer, with</p> | F 309 | | |
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| F 309 | <p>Continued From page 2</p> <p>maggots infecting the wound. R1 was admitted to the hospital from 8/14/15 to 8/20/15 for treatment of the infected wound, and pain control. The wound was cleansed and visible maggots removed, and C1 received intravenous antibiotics.</p> <p>LPN- F was interviewed on 8/28/15 at 3 p.m. and verified that the dressing changes were not completed for 8/10/15, 8/11/15, and 8/12/15 because he misread the order and just checked that the dressing was in place and did not change the dressing.</p> <p>The progress note dated 8/14/15 by RN-D documented that the dialysis social worker had called to state that R1 had arrived for dialysis with a foul body odor. The social worker also expressed concern that R1 did not have a dressing covering the catheter site on the chest several times when R1 arrived for dialysis.</p> <p>The Social Worker was interviewed on 9/3/15 at 1:40 p.m., and stated that the missing dressing to the catheter continues to be an ongoing issue, that there is no dressing in place when C1 arrived at the dialysis clinic.</p> <p>The treatment record includes an order dated 2/13/15 to check the dressing every shift and to keep the catheter covered with a gauze dressing.</p> <p>R1 was observed on 8/28/15 at 2 p.m. to have a dressing on the right leg which fully covered the wound, and a gauze dressing to his right chest area. R1 was seated in a wheelchair and pushed himself around with his right leg. R1 was interviewed and said that his leg hurt a lot more when he went to the hospital but has improved.</p> | F 309 | | |

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| F 309 F 314 SS=G | <p>Continued From page 3</p> <p>R1 declined having the dressing removed at this time so wound could be observed.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess for risk factors and update the care plan for 2 of 2 residents with pressure ulcers (R2 and R3). This resulted in harm for R2 when a recurring stage 3 ulcer developed at the facility.</p> <p>Findings include:</p> <p>The medical record was reviewed for R2. R2 had diagnoses of dementia and heart failure, and had been at the facility over 2 years. R2 had a guardian appointed to make all decisions. R2 developed a recurrent stage 3 ulcer on the ankle and did not have a comprehensive assessment of the risk factors to prevent the recurrence. The care plan and the nursing assistant care guide had not been updated with treatment of the wound and additional preventative measures. R2 had a history of pressure ulcers noted on the care</p> | F 309 F 314 | | |

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| F 314 | <p>Continued From page 4</p> <p>plan dated 3/9/15, and R2 was to wear a heel boot and have a weekly skin assessment.</p> <p>An "Investigative Wound Flowsheet" dated 7/22/15 noted that the left ankle had a new pressure are measuring 2 c.m. by 2 c.m., of suspected deep tissue injury. The summary noted that this is a chronic area that had been open in the past, and the "action taken" was to notify the nurse practitioner. There was not a risk assessment or Braden scale completed at this time.</p> <p>The care plan was not changed or updated since 3/9/15 to include the care to the wound or preventative measures to address the risk factors.</p> <p>The "Investigative Wound Flowsheet" dated 7/30/15 noted the ankle wound to be the same size and was assessed as a stage 3 pressure ulcer. The "Investigative Wound Flowsheet" dated 8/24/15 noted the wound measured 1.5 c.m. by 1.5 c.m. and was a stage 3 pressure ulcer. On 8/24/15 the contributing clinical condition was identified as non-compliance and shearing of lower extremities in bed. There was no updates to the care plan to address these factors. The treatment sheets and the progress notes did not document each refusal of wound cares or the boot, or include interventions to increase the resident's compliance with treatment.</p> <p>R2 was observed on 8/28/15 at 10:15 a.m. to have a dressing change to the ankle wound by RN-D. R2 was seated in the wheelchair with white athletic socks on and no shoes. The nurse removed the socks and did not find the dressing that was supposed to be on the leg, the wound</p> | F 314 | | | |

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| F 314 | <p>Continued From page 5</p> <p>was uncovered. The leg was swollen and had an indentation from the top of the sock, the wound was a round scabbed area on the ankle bone on the outside of the left ankle. RN-D verified that a dressing should have been on the wound, she stated that the wound was getting better but was not measured. RN-D applied bacitracin ointment and covered the wound with an Allyvn (foam) dressing. An Ace bandage was applied to both legs. R2 was quiet and agreeable during the dressing change but was very confused. RN-D cut the elastic top of the sock and put them on, no shoes or the pressure reduction boot were offered to R2. His feet were on the floor surface and he pushed his feet to propel the wheelchair.</p> <p>On 8/28/15 at 2:40 p.m. RN-E went to R2's room he was seated in the wheelchair with Ace wraps and socks on both feet. RN-E located the pressure reducing boot in R2's closet. It was a blue boot with velcro straps to relieve pressure to the heel area, and the ankle bone area would be between the straps. There were also a pair of special shoes with velcro straps to adjust the tightness. RN-E said they weren't on because R2 refuses. When RN-E offered the shoes to R2, he agreed and the shoes were placed on his feet. RN-E was not sure how often R2 was offered the boot or shoes, the treatment record did not record staff attempting the boot or shoes.</p> <p>The Director of Nursing (DON) was interviewed on 8/28/15 at 4:20 p.m. and stated that the comprehensive assessment for skin risk would include a Braden scale (a tool to measure the risk for skin breakdown) on admission, quarterly and with a change in condition in the skin. She stated the cause of skin breakdown on the ankle for R2 was due to friction and shearing when in bed, she</p> | F 314 | | | |

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| F 314 | <p>Continued From page 6</p> <p>stated that no new interventions were in place to reduce the risk factors since the development of the stage 3 ulcer. She stated that the floor nurses should updated the care plan and the DON should monitor this process. She also stated that R2 was not compliant with cares unless certain staff provided cares.</p> <p>R3's medical record was reviewed. R3 had diagnoses of dementia, falls, and pneumonia; and had lived at the facility since 2013. R3 was hospitalized for pneumonia and returned to the facility on 8/8/21/15 with 2 stage 2 pressure ulcers on the buttocks. R3 was assessed as a high risk for pressure ulcers on return from the hospital, but the plan of care had not been updated.</p> <p>R3 was observed at 9:30 a.m. on 8/28/15 in bed calling out "get me up" a nurse and the nursing assistants went into the room and reminded her she had just laid down and needed to rest. R3 appeared agitated and confused, lying on her back with the head of bed up slightly.</p> <p>The progress notes documented R3 was sent to the hospital on 8/4/15 for treatment of pneumonia, and returned to the facility 8/21/15. The admission nursing assessment dated 8/21/15 noted 2 stage 2 pressure ulcers, the right buttock measured 3 c.m. by 2.5 c.m., the left buttock 1.5 c.m. by 1 c.m., a Braden Scale was completed on 8/21/15 and assessed that R3 was very high risk for pressure ulcers. The nursing progress note dated 8/21/15 documented that R3 needed total staff assistance to turn reposition and transfer.</p> | F 314 | | | |

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| F 314 | <p>Continued From page 7</p> <p>The Investigative Skin Flowsheet dated 8/28/15 noted that Lantiseptic ointment to the wound, and that C3 required repositioning and incontinent care every 2 hours.</p> <p>The current plan of care dated 3/17/15 for skin noted that skin was intact and had not been updated to reflect the current mobility and care needs. There were no temporary interventions on the care plan for the increased care needs.</p> <p>The DON was interviewed 8/28/15 at 4:15 p.m. and stated the plan of care should be up to date and reflect the assessed needs.</p> | F 314 | | | |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00167 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER BETHANY RESIDENCE AND REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |
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| 2 000 | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5578017. As a result, the following correction orders are issued.</p> <p>The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of</p> | 2 000 | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00167 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER BETHANY RESIDENCE AND REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |
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| 2 000 | Continued From page 1 Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the 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 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide dressing changes, and failed to maintain a dressing on the dialysis catheter for 1 of 1 residents (R1) reviewed for non pressure related wounds. This | 2 830 | | |

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| 2 830 | <p>Continued From page 2</p> <p>resulted in harm for R1 when the leg wound became infected and painful, and R1 required hospitalization.</p> <p>Findings include:</p> <p>R1 medical record was reviewed. R1 had a diagnosis of chronic kidney disease, dementia and venous insufficiency. The plan of care dated 2/19/13 noted R1 received hemodialysis 3 times a week, had a central venous catheter (CVC) in the upper chest which was to be covered with a dry dressing. The care plan directed staff to observe for signs of infection and bleeding at the catheter site. The care plan dated 2/20/13 noted R1 needed assist of one staff for transfers, dressing, bathing and grooming.</p> <p>The physician's note dated 8/3/15 documented that R1 had a venous wound on the right middle leg that had been open for 141 days, had light serous (light colored or clear) drainage, and no pain. The wound measured 3.6 c.m. by 2.6 c.m. with a depth of 0.2 c.m. On 8/3/15, the physician ordered Santyl ointment (An enzymatic debriding ointment, that works by breaking down dead skin.) daily to the wound and cover with adhesive foam.</p> <p>On 8/13/15 the nurse noted on the weekly skin checklist, that the wound bed was dark red with inflamed tissue surrounding and a foul odor.</p> <p>RN-H was interviewed on 9/3/15 at 1:40 p.m. and said the dressing removed on 8/13/15 had the date '8/9/15' written on it, and was the same dressing she had applied on Sunday, 8/9/15. RN-H reported the error to the Director of Nursing (DON). RN-H stated the dressing was changed on 8/14/15, when the dressing was removed</p> | 2 830 | | |
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| 2 830 | <p>Continued From page 3</p> <p>there were several white crawling bugs in the wound and under the scabbed areas on the side of the wound. RN-H stated she covered the wound and sent R1 to the hospital.</p> <p>The hospital discharge summary dated 8/20/15 noted admission diagnoses of right lower extremity pain of the chronic venous ulcer, with maggots infecting the wound. R1 was admitted to the hospital from 8/14/15 to 8/20/15 for treatment of the infected wound, and pain control. The wound was cleansed and visible maggots removed, and C1 received intravenous antibiotics.</p> <p>LPN- F was interviewed on 8/28/15 at 3 p.m. and verified that the dressing changes were not completed for 8/10/15, 8/11/15, and 8/12/15 because he misread the order and just checked that the dressing was in place and did not change the dressing.</p> <p>The progress note dated 8/14/15 by RN-D documented that the dialysis social worker had called to state that R1 had arrived for dialysis with a foul body odor. The social worker also expressed concern that R1 did not have a dressing covering the catheter site on the chest several times when R1 arrived for dialysis.</p> <p>The Social Worker was interviewed on 9/3/15 at 1:40 p.m., and stated that the missing dressing to the catheter continues to be an ongoing issue, that there is no dressing in place when C1 arrived at the dialysis clinic.</p> <p>The treatment record includes an order dated 2/13/15 to check the dressing every shift and to keep the catheter covered with a gauze dressing.</p> | 2 830 | | |

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| 2 830 | Continued From page 4 R1 was observed on 8/28/15 at 2 p.m. to have a dressing on the right leg which fully covered the wound, and a gauze dressing to his right chest area. R1 was seated in a wheelchair and pushed himself around with his right leg. R1 was interviewed and said that his leg hurt a lot more when he went to the hospital but has improved. R1 declined having the dressing removed at this time so wound could be observed. Suggested Method of Correction: The director of nurses and or designee could review pertinent policies and procedures, updated as necessary, educate the staff, and implement a monitoring system to ensure compliance. Time Period for Correction: Twenty-one (21) Days. | 2 830 | | |
| 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. | 2 900 | | |

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| 2 900 | <p>Continued From page 5</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to assess for risk factors and update the care plan for 2 of 2 residents with pressure ulcers (R2 and R3). This resulted in harm for R2 when a recurring stage 3 ulcer developed at the facility.</p> <p>Findings include:</p> <p>The medical record was reviewed for R2. R2 had diagnoses of dementia and heart failure, and had been at the facility over 2 years. R2 had a guardian appointed to make all decisions. R2 developed a recurrent stage 3 ulcer on the ankle and did not have a comprehensive assessment of the risk factors to prevent the recurrence. The care plan and the nursing assistant care guide had not been updated with treatment of the wound and additional preventative measures. R2 had a history of pressure ulcers noted on the care plan dated 3/9/15, and R2 was to wear a heel boot and have a weekly skin assessment.</p> <p>An "Investigative Wound Flowsheet" dated 7/22/15 noted that the left ankle had a new pressure are measuring 2 c.m. by 2 c.m., of suspected deep tissue injury. The summary noted that this is a chronic area that had been open in the past, and the "action taken" was to notify the nurse practitioner. There was not a risk assessment or Braden scale completed at this time.</p> <p>The care plan was not changed or updated since 3/9/15 to include the care to the wound or preventative measures to address the risk</p> | 2 900 | | |

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| 2 900 | <p>Continued From page 6</p> <p>factors.</p> <p>The "Investigative Wound Flowsheet" dated 7/30/15 noted the ankle wound to be the same size and was assessed as a stage 3 pressure ulcer. The "Investigative Wound Flowsheet" dated 8/24/15 noted the wound measured 1.5 c.m. by 1.5 c.m. and was a stage 3 pressure ulcer. On 8/24/15 the contributing clinical condition was identified as non-compliance and shearing of lower extremities in bed. There was no updates to the care plan to address these factors. The treatment sheets and the progress notes did not document each refusal of wound cares or the boot, or include interventions to increase the resident's compliance with treatment.</p> <p>R2 was observed on 8/28/15 at 10:15 a.m. to have a dressing change to the ankle wound by RN-D. R2 was seated in the wheelchair with white athletic socks on and no shoes. The nurse removed the socks and did not find the dressing that was supposed to be on the leg, the wound was uncovered. The leg was swollen and had an indentation from the top of the sock, the wound was a round scabbed area on the ankle bone on the outside of the left ankle. RN-D verified that a dressing should have been on the wound, she stated that the wound was getting better but was not measured. RN-D applied bacitracin ointment and covered the wound with an Allyvn (foam) dressing. An Ace bandage was applied to both legs. R2 was quiet and agreeable during the dressing change but was very confused. RN-D cut the elastic top of the sock and put them on, no shoes or the pressure reduction boot were offered to R2. His feet were on the floor surface and he pushed his feet to propel the wheelchair.</p> <p>On 8/28/15 at 2:40 p.m. RN-E went to R2's room</p> | 2 900 | | |

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| 2 900 | <p>Continued From page 7</p> <p>he was seated in the wheelchair with Ace wraps and socks on both feet. RN-E located the pressure reducing boot in R2's closet. It was a blue boot with velcro straps to relieve pressure to the heel area, and the ankle bone area would be between the straps. There were also a pair of special shoes with velcro straps to adjust the tightness. RN-E said they weren't on because R2 refuses. When RN-E offered the shoes to R2, he agreed and the shoes were placed on his feet. RN-E was not sure how often R2 was offered the boot or shoes, the treatment record did not record staff attempting the boot or shoes.</p> <p>The Director of Nursing (DON) was interviewed on 8/28/15 at 4:20 p.m. and stated that the comprehensive assessment for skin risk would include a Braden scale (a tool to measure the risk for skin breakdown) on admission, quarterly and with a change in condition in the skin. She stated the cause of skin breakdown on the ankle for R2 was due to friction and shearing when in bed, she stated that no new interventions were in place to reduce the risk factors since the development of the stage 3 ulcer. She stated that the floor nurses should updated the care plan and the DON should monitor this process. She also stated that R2 was not compliant with cares unless certain staff provided cares.</p> <p>R3's medical record was reviewed. R3 had diagnoses of dementia, falls, and pneumonia; and had lived at the facility since 2013. R3 was hospitalized for pneumonia and returned to the facility on 8/8/21/15 with 2 stage 2 pressure ulcers on the buttocks. R3 was assessed as a high risk for pressure ulcers on return from the hospital, but the plan of care had not been updated.</p> | 2 900 | | |

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| 2 900 | <p>Continued From page 8</p> <p>R3 was observed at 9:30 a.m. on 8/28/15 in bed calling out "get me up" a nurse and the nursing assistants went into the room and reminded her she had just laid down and needed to rest. R3 appeared agitated and confused, lying on her back with the head of bed up slightly.</p> <p>The progress notes documented R3 was sent to the hospital on 8/4/15 for treatment of pneumonia, and returned to the facility 8/21/15. The admission nursing assessment dated 8/21/15 noted 2 stage 2 pressure ulcers, the right buttock measured 3 c.m. by 2.5 c.m., the left buttock 1.5 c.m. by 1 c.m., a Braden Scale was completed on 8/21/15 and assessed that R3 was very high risk for pressure ulcers. The nursing progress note dated 8/21/15 documented that R3 needed total staff assistance to turn reposition and transfer.</p> <p>The Investigative Skin Flowsheet dated 8/28/15 noted that Lantiseptic ointment to the wound, and that C3 required repositioning and incontinent care every 2 hours.</p> <p>The current plan of care dated 3/17/15 for skin noted that skin was intact and had not been updated to reflect the current mobility and care needs. There were no temporary interventions on the care plan for the increased care needs.</p> <p>The DON was interviewed 8/28/15 at 4:15 p.m. and stated the plan of care should be up to date and reflect the assessed needs.</p> <p>Suggested Method of Correction: The director of nurses and or designee could review pertinent policies and procedures, updated as necessary, educate the staff, and implement a monitoring</p> | 2 900 | | |

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| 2 900 | Continued From page 9 system to ensure compliance. Time Period for Correction: Twenty-one (21) Days. | 2 900 | | |

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.

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| (Y1) Provider / Supplier / CLIA / Identification Number 245578 | (Y2) Multiple Construction A. Building _____ B. Wing _____ | (Y3) Date of Revisit 10/19/2015 |
| Name of Facility BETHANY RESIDENCE AND REHABILITATION CENTER | | Street Address, City, State, Zip Code 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |

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 F0309 | Correction Completed 10/14/2015 | ID Prefix F0314 | Correction Completed 10/14/2015 | ID Prefix _____ | Correction Completed |
| Reg. # 483.25 | _____ | Reg. # 483.25(c) | _____ | Reg. # _____ | _____ |
| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |
| ID Prefix _____ | Correction Completed | ID Prefix _____ | Correction Completed | ID Prefix _____ | Correction Completed |
| Reg. # _____ | _____ | Reg. # _____ | _____ | Reg. # _____ | _____ |
| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |
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| LSC _____ | _____ | LSC _____ | _____ | LSC _____ | _____ |
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| Reviewed By _____ | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |
| State Agency _____ | _____ | _____ | _____ | _____ |
| Reviewed By _____ | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |
| CMS RO _____ | _____ | _____ | _____ | _____ |

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| Followup to Survey Completed on: 9/14/2015 | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right; margin-left: 20px;"> <tr> <td>YES</td> <td>NO</td> </tr> </table> | YES | NO |
| YES | NO | | |

State Form: Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number 00167 | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit 10/19/2015 |
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| Name of Facility BETHANY RESIDENCE AND REHABILITATION CENTER | Street Address, City, State, Zip Code 2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418 |
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|--|---|--|---|--|----------------------|
| ID Prefix <u>20830</u> Reg. # <u>MN Rule 4658.0520 Subp.</u> LSC _____ | Correction Completed <u>10/14/2015</u> | ID Prefix <u>20900</u> Reg. # <u>MN Rule 4658.0525 Subp.</u> LSC _____ | Correction Completed <u>10/14/2015</u> | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |
| ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed | ID Prefix _____ Reg. # _____ LSC _____ | Correction Completed |

| | | | | |
|---|--------------------------|--------------------|-------------------------------------|--------------------|
| Reviewed By _____ State Agency | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |
| Reviewed By _____ CMS RO | Reviewed By _____ | Date: _____ | Signature of Surveyor: _____ | Date: _____ |

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|--|---|
| Followup to Survey Completed on: 9/14/2015 | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
|--|---|