Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail #

November 20, 2019

Administrator
Able Inc - LaCrescent
1700 Lancer Blvd
La Crescent, MN 55947

RE: Project Number HG380003C

Dear Administrator:

On September 12 & 13, 2019 an abbreviated survey was completed to investigate complaint #HG380003C. Able INC Lacrescent is not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities.

The complaint was substantiated at W342.

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

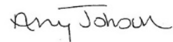
Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite 2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Please note, it is your responsibility to share the information contained in this letter and the results of the visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,



Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

cc: Licensing and Certification File

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Administrator
Able Inc - Lacrescent
1700 Lancer Blvd
La Crescent, MN 55947

Re: Project Number: HG380003C

Dear Administrator:

On September 12 & 13 a complaint investigation was conducted to investigate complaint #HG380003C. Able INC Lacrescent is in full compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G380	A. BUILDING ______ B. WING ______	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABLE INC - LACRESCENT	1700 LANCER BLVD LA CRESCENT, MN 55947

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W 000	INITIAL COMMENTS On September 12 & 13, 2019 an abbreviated survey was completed to investigate complaint #HG380003C. Able INC Lacrescent is not in compliance with 42 CFR Part 483, subpart I, requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities. The complaint was substantiated at W342.	W 000 Maria King ok		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure direct care staff reported signs and symptoms of illness, including signs of urinary tract infection for 1 of 1 client (C1) who had a history of urinary tract infections. Findings include: C1's progress notes were reviewed from 8/26-9/3/19. C1's program notes for RDLs (routine daily living skills) and progress note dated 9/1/19 included, "C1 had a relaxing morning. Worked well with staff. Only concern: Strong odor when toileting."	W 342	For persons supported with known medical histories and who are prone to chronic conditions, signs and symptoms of these specific illnesses are listed in the SMA. At hire, new employees will read PS documents and sign to acknowledge when they have read these. With every Annual/Semi Annual review, documents are again provided when ready to be reviewed and they must sign off on these as acknowledgement when completed. Staff signatures indicate documents are read and understood. SMA's medical information will be reviewed for each person residing in an ABLE ICF and updated as needed. To be completed 03/05/2020 During orientation to the units and the people supported, all staff are educated on signs and symptoms requiring a call to a nurse. Ongoing During initial TMA (Trained Medication Aide) and yearly refreshers courses staff are given handouts with directions on when to call a nurse. These are reviewed with all staff. Ongoing	

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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W 342	Continued From page 1	W 342		

C1's nursing progress note dated 9/4/19, at 7:09 a.m. included, "Call this morning regarding C1. Staff stated that they had a hard time waking her up this morning and her temperature was high for her at 99.7. Whenever she has any mental status changes we have been asked to take her in to the doctor. She is being taken to the ER (emergency room) right now. Guardian and CM (case manager) aware."

C1's nurse progress note dated 9/4/19, at 11:23 a.m. included, "C1 has been admitted to the hospital due to sepsis related to a UTI (urinary tract infection). She is on an antibiotic at this time. The hospital did tell staff that she would be staying in the hospital for a few days. Guardian and CM (case manager) notified."

Another nurse progress note dated 9/4/19, at 1:04 p.m. included a note from the local hospital link: "Labs are obtained which show a leukocytosis with left shift, chronic anemia. Lactic acid is not elevated. Electrolytes and renal function are at baseline. Catheterized urine specimen shows positive nitrites, greater than 50 bacteria. Culture is sent on this. The patient was started on empiric ceftriaxone for sepsis. She is receiving IV (intravenous) fluid. She remains tachycardic but not hypotensive. Physician (P)-A will admit the patient for further treatment."

C1's hospital discharge summary dated 9/6/19, included: ..." DEATH SUMMARY...SUMMARY OF ADMISSION..."non-verbal female with Lennox-Gastaut syndrome with parital compelx sezures, struvite kidney stones, psychomotor retardation and a history of MRDO (multi-drug resistant organism) uti's (urinary tract infection)

Provider's Plan of Correction (W 342):

During unit specific staff meetings each person supported's health and safety needs are reviewed. Any health or medical concerns are brought to the attention of the nurse to follow up on. When any change in condition is detected the nurse will use T-logs and/or SComms (electronic email) as a way to communicate changes such as medications/treatments to be completed and signs and symptoms to monitor for and alert nurse if present. Staff are required to read all T-logs/SComms dating from the last day worked to present to be updated on any PS changes. Ongoing

Supervisory staff will monitor that all necessary staff signatures or acknowledgments are present for annual documents, (example: SMA, CSSP addendum and IAPP). Staff who have not signed/acknowledged these documents may be subject to corrective action as noted in the employee handbook. Ongoing

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W 342	Continued From page 2 with sepsis who presents with recurrent sepsis from UTI. Per report, the patient was found to have an altered mental status today and was febrile. A caregiver states he was told she was wheezing as well. She was sent into the ER (emergency room) where she was found to be tachycardic tachypneic and to also have a temp. Work up included a negative CXR (chest x-ray) negative CT abdomen and pelvis without, and a positive U/A (urinalysis). She is now admitted due to sepsis from UTI. Due to the patient being non-verbal, she cannot assist with any history...HOSPITAL COURSE: was admitted with sepsis d/t UTI. Given her history of MDRO (multi drug resistant organism), she was treated with IV (intravenous) Zosyn (an antibiotic). She initially required IV Ativan for her Lennox-Gastaut Seizure as she was too enchalopathic to take her PO (oral) meds. However, she quickly improved and became more alert and was able to take her regular medications. Her fevers resolved after admission and did not return. On 9/5, ...She was being lowered on the lift back into her chair after a BM (bowel movement), at which point she became unresponsive, was tachy in 130's and had O2 sats (oxygen saturations) in 70s. Upon arrival to the room, her room o2 sats (oxygen saturations) were back in 90's on room air, and HRs (heart rate) had improved to low 100s. BP (blood pressure) was stable 135/64. There was no witnessed tonic-clonic seizure activity or other seizure-like activity. A few minutes later, she opened her eyes and was functioning closer to her nonverbal baseline. Was noted to be tachypnic with coarse breath sounds...She may have become hypotensive with sepsis, but may also have had a vasovagal episode...Testing was generally unremarkable....Her tachycardia quickly resolved and her vitals remained stable	W 342		

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W 342	Continued From page 3 throughout the night...Unfortunately, in teh early morning hours of 9/6, telemetry noted asystole. Patient had faint carotid pulse...Patient quickly lost pulse and stopped breathing. DNR/DNI code status was confirmed. Guardian/mother was updated. Cause of deathy likely complications from sepsis. " Review of C1's record indicated C1 was susceptible to urinary tract infections: Multiple drug resistant organism (MDRO) positive, identified 12/23/15. A Quick Note and Emergency Procedure for C1 updated 10/2017 included: "Frequent urinary tract infections: If C1's urine is stronger than normal, if she is incontinent more than her normal, or is she shows signs of pain when she is on the toilet, immediately notify the RN [registered nurse], PD [program director], or the on-call system." C1's health care care plan/instructions dated 1/24/18, included: "[C1] ... having some strong smelling urine ...A urine test would show bacteria as it always does, so a urine test isn't really all that helpful at this time. Please check [C1's] temperature daily in the morning and before bed. Let the nurses know if she has any mental status changes." C1's Self-Management Assessment updated 4/18/19, identified diagnosis of profound mental retardation and epilepsy. The assessment indicated C1 was non-verbal, had a history of frequent urinary tract infections and included, "Staff are trained to monitor C1's incontinences and verbally inform a nurse or supervisor if her urine smells especially strong or if urine output is	W 342		

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W 342	Continued From page 4 significantly less or greater than normal or if she has an elevated temperature. Staff should offer C1 fluids throughout the day, help her use the toilet every hour, and change her attends as soon as possible if she has been incontinent." The assessment further identified C1 was unable to seek attention for illness, injury or other medical needs. The assessment directed staff to monitor for signs of illness, injury or other health needs and to report concerns to nursing staff, a supervisor, or program director. A Urology Visit Note dated 5/21/19 included: "History: [C1] has a history of struvite stones and is s/p [status post] percutaneous nephrostolithotomy on 10/15/17 and 9/28/17. She was treated with antibiotics per ID [infectious disease] when the perc tube was removed. She had a history of MDRO. She was hospitalized with sepsis September 2017 prior to perc placement. After two procedures for stone removal, she was placed on lithostat, which she could not tolerate. She was seen by Infectious Disease in 12/15, with the recommendation she only be treated for UTI [urinary tract infection] or stone when she is symptomatic with fever, chills ect. She is not able to answer any questions ...Per infectious disease she is not to be placed on prophylactic antibiotics since that would eliminate another choice if she should need treatment." During interview 9/12/19, at 11:23 a.m. direct support professional (DSP)-A stated she did not recall changes in C1's urine including odor, from any other day. DSP-A stated, "[C1] had a semi-strong urine odor sporadically and but did not have strong urine odor. I just noticed she looked tired, but she was always sleeping and on	W 342		

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W 342	Continued From page 5 Sunday (9/1/19) we walked her and she was normal in her activities with staff." DSP-A further stated, "On Monday she seemed more tired, but that was the only real difference. Her transfers were normal and we did not need to do anything different with her. We provided normal cares both Monday and Sunday. I was really surprised this came on so sudden for her. I have worked with her the last three years." During the interview, DSP-A was able to identify symptoms to monitor for to identify whether C1 had an UTI including: urine darker, stronger urine odor and if she slows down or is not be able to walk. DSP-A stated C1's eating and drinking patterns had been normal. DSP-A stated, "I absolutely not did not have any concerns she was getting sick. Her temperature was in normal range and visual expressions were the same. She had no changes in her behavior or presentation that was why I was pretty surprised to hear of her quick decline." At 2:36 p.m., when DSP-A was interviewed regarding the 9/1/19 progress note where she'd recorded, "Only concern: Strong odor when toileting." DSP-A stated, "I just put that in the notes and did not report that to anyone else. It was just in the record. I charted the concern as I know she has UTI issues, and wanted those staff who come after me to be observant. I did not think it was something to call the nurse about." DSP-A stated, "only when on the edge of having a UTI infection does [C1] have a strong urine odor. I just wanted my colleagues to be aware of this to monitor for the next shift." DSP-A also stated if C1 had an UTI infection coming on it would be prolonged odor. DSP-A stated, "Not at all did I consider it to be a change in [C1's] condition, nothing highly unusual that would have required a trip to the ER (emergency room) sooner than later. I guess I just know these girls [the clients]	W 342		

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W 342	Continued From page 6	W 342		

so well, I would notify the nurse if I felt there was a threat to their wellbeing or if they were unstable."

On 9/12/19, at 3:10 p.m. the health services director (HSD) stated according to the doctor notes, they were not going to treat (for a urinary tract infection) unless C1 had altered mental status or an elevated temperature. HSD stated she would have expected the direct support professional (DSP) to report to the nurse any concern related to C1 having strong urine odor. HSD stated it was not appropriate for DSP-A to document this but not tell anybody. The HSD further stated if she had been aware of the note (regarding the concern with strong urine odor) she would have contacted the physician. The HSD stated nursing was not made aware of any concerns with the C1 until 9/4/19 and stated, "I would have expected the concern to be reported, and the nurse would have called the on-call physician." The HSD confirmed she would have told staff to monitor C1's temperature and follow the protocol suggested by the doctor, and if C1 turned worse, she would have directed staff to take C1 to the ER. The HSD also stated the protocol expectation for urinary tract infection was in C1's Self-management Assessment. HSD again stated it had been made clear they were not going to treat (C1 for a urinary tract infection) unless there was altered mental status or fever. HSD stated, "Even so, I would still want to inform the physician of the change of urine odor and then they can direct staff. Temperatures were being done daily, related to history of urinary tract infections and upper respiratory infections."

On 9/13/19, at 12:09 p.m. registered nurse (RN)-A and HSD were interviewed. RN-A stated,

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W 342	Continued From page 7 "Staff will let me know if C1's urine smells strong or if she has a change in urine color. RN-A stated, "I had been having them checking her temperature once daily and the cranberry probiotic seemed to help her. If C1 displayed mental status changes staff were to call me so she could be sent in (to the emergency room). Staff know [C1] has chronic UTIs, they were told she had constant UTIs and to look for strong smelling urine and dark colored urine." Further, RN-A stated if C1's temperature was above 100, or less than 96, staff needed to call her right away because it could be a sign C1 was getting sick and could be septic. HSD then reiterated C1's self-management assessment was supposed to be reviewed by staff upon hire, on an annual basis, and when there were any revisions made to the self-management assessment. On 9/13/19, at 3:08 p.m. DSP-A stated she was trained on how to recognize C1's symptoms of an UTI by the resident assessment that described C1 and stated employees had to sign off on this. DSP-A stated each client had an individual management program and everything she would need to know about C1 was in there for her to be able to do her job. DSP-A stated, "We review the insert sheets (updates on the client) that come in from time to time. The nurse is good about informing us."	W 342		