MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
KSMS Our House LLC
204 14th Street Northwest
Austin, MN 55912
Mower County

Report #: HL20449014

Date: November 13, 2014

Date of Visit: January 30 and 31, 2014
Time of Visit: 8:00 a.m. – 4:30 p.m.
8:00 a.m. – 3:00 p.m.

By: Elizabeth Swan, R.N., Special Investigator
Austin Fry, 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 neglect of health care occurred when the alleged perpetrator (AP) failed to assess a client #1's pain. The client had a broken leg. In addition; the AP failed to send another client #2 to the hospital in a timely manner after a change in health status.

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 preponderance of evidence neglect did occur when a client's change in condition was not assessed by the AP to ensure timely medical intervention.

The client had diagnoses that included diabetes mellitus, chronic obstructive pulmonary disease (COPD), Coronary Artery Disease (CAD) and Asthma. The client received assistance of one staff with activities of daily living (ADL) skills that included walking, medication administration, and daily accucheck (blood sugar monitoring). The client was independent with administration of his/her insulin injections. The client's medication regimen included pain control of Oxycontin (narcotic) 30 milligrams (mg) extended release tablets, take one tablet by mouth every 12 hours, Oxycodone/APAP (narcotic) 5-325 mg tablet; take one to two tablets by mouth every 4 - 6 hours as needed for pain.

On the morning of the client's change in condition, at 8:00 a.m., the staff identified, the client was "pretty out of it". The client had oxygen levels of 86% to 93%, required assistance to put medications in his/her mouth, and was unable to self- administer the insulin. The staff notified the AP of the client's change in condition. The AP instructed staff to administer the client's insulin, but did not assess the client's condition in relation to the altered mental status and inability to self-administer medications. The AP did not provide the staff with any parameters for monitoring the client or when to call the AP back. In addition, the AP informed the staff not to call 911 unless the client was unconscious. Later the same day, on the evening shift of work, the client was not able to stand up. The staff notified the AP of the client's inability to stand. The AP instructed staff to use a mechanical lift for transfers without an assessment of the client's continued change in condition and inability to stand. The AP did not ask the staff for an update on the client's status or provide the staff with any parameters for monitoring the client or when to call the AP back. Eleven hours after the first reported change in the client's condition, the client's condition had not improved and staff identified the client had an oxygen level of 86%, and a temperature of 101.5. Staff did not call the AP for direction instead called 911 and the client was transported to the hospital and admitted to the hospital intensive care unit with diagnosis of Toxic/metabolic encephalopathy from CO2 retention and respiratory acidosis, inadvertent overdose with OxyContin and Oxycodone, Intermittent myoclonic jerks, acute delirium and pneumonia – likely from aspiration. The client returned to the facility after a five-day hospital stay.

The facility's policy of When to Notify Director Or Designee During Non-Normal Working Hours Or At Any Time of Incident, identified reasons when the director or designee should be contacted. The list of reasons included at #7 when a resident required medical attention and at #8 when a resident is non-responsive. The

policy also identified that the list was not inclusive and only represented some of the most important reasons to call the director or designee. Although the policy identified reasons to contact the director or designee, the policy failed to identify the responsibility of the director or designee.

On interview, the AP verified staff notified him/her on two occasions of the client's changes in condition. The AP also verified he/she instructed the unlicensed personnel not to send the client to the hospital due to the client having prior episodes of pneumonia, and recent hospitalizations.

On interview, the client could not remember the events of the day. The client's family had no concerns.

The failure to assess another client for pain was not substantiated. Although the client had sustained a fracture, there was no evidence to support that the client had exhibited pain prior to the day and time of occurrence. The client's family had no concerns. The client was not in the facility during the onsite visit.

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:

Although the facility had a policy and procedure that directed staff when to call the AP with a clients' change in condition, the policy and procedure failed to identify the expectation of the AP and the responsibility of the AP when notified of changes in the clients' 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:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) 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 Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):
A licensing order follow up visit completed on June 13, 2014, found the facility back in compliance.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated," means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

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

☒ Medical Records

☒ Care Guide

☒ Medication Administration Records

☒ Treatment Sheets

☒ Facility Incident Reports

☐ ADL (Activities of Daily Living) Flow Sheets

☒ Physician Orders

☒ Nurses Notes

☐ Activities Reports

☐ Therapy and/or Ancillary Services Records

☒ Skin Assessments

☒ 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.

☐ Facility Internal Investigation Reports

☐ Call Light Audits

☒ Personnel Records/Background Check, etc.

☐ Facility In-service Records

☒ Facility Policies and Procedures

☐ Other, specify: _____

Number of additional resident(s) reviewed: 6

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: 10

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 8

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner 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

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 Nursing
Austin City Police Department
Mower County Attorney
Austin City Attorney

Minnesota Department of Health

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	H20449	A. BUILDING: _____ B. WING _____	C 02/14/2014

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0 000	Initial comments A complaint investigation was initiated on January 30, 2014, to investigate case #HL20449014. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970. RECEIVED APR - 8 2014	0 000	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 Home Care Providers. 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. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is 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.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030		

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide care and services according to acceptable standards of practice related to diabetic monitoring for three of three (C1, C5 and C6) clients in the sample who received blood glucose monitoring, and failed to provide nursing assessments when a change in condition was reported for three of four (C2, C4 and C5) clients in the sample who exhibited changes in their condition related to infections and/or falls. The findings include: Diabetic Monitoring Client #1 (C1) was admitted for services on November 14, 2012, with diagnoses that included diabetes mellitus, Chronic Obstructive Pulmonary disease (COPD) Coronary Artery Disease (CAD) and Asthma. The Discipline Frequency form identified C1 received assist with activities of daily living (ADL) skills, and medication set up and treatments as indicated on the Individual Service Plan (ISP). The ISP updated on November 14, 2013, identified the client received daily Accuchecks (blood sugar monitoring) and staff assistance with medication administration.	0 030		

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0 030	Continued From page 2 Physician orders renewed on November 30, 2013, identified C1 received Lantus Insulin 20 units daily at bedtime. The physician orders also included a daily check of C1's blood sugar. On review of the December 2013 medication administration record (MAR), it was noted the Lantus insulin order identified the insulin was to be given at bedtime, but staff initialed the insulin was administered at 8:00 a.m. The blood glucose test was done at 6:00 a.m. On December 25, 2013, the client's 6:00 a.m. blood glucose test was 133 (70 - 115 desired range). C1's record revealed that on December 25, 2013, on the 7-3 shift, unlicensed personnel (ULP) documented on the Resident Log that the client was found "pretty out of it". The documentation indicated the client required help to put her medications in her mouth, and that she could not dial her insulin pen nor was she able to self administer her insulin. The documentation also identified the client's oxygen saturation levels were 86% to 93%. The ULP documented the nurse on call was notified of the client's change in mental status and oxygen levels. The ULP documented the RN instructed the ULPs to give C1 her insulin and that the nurse said "we can't send her in until she is unconscious." The Resident Log ULP documentation on December 25, 2013, for the 3-11 shift identified C1 could not stand up. The documentation identified the on call nurse was again notified of the change in the client's condition. The documentation indicated the ULP staff were instructed to use the mechanical lift for transfers if the client could not stand. The documentation identified C1 told the ULP she wanted to go to the hospital. The ULP's called for transport and C1	0 030		

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0 030	Continued From page 3 was admitted to the hospital. When interviewed on January 30, 2014, ULP-F stated she routinely provided care for C1. ULP-F stated C1 was alert and able to dial her insulin pen to the correct dose and was able to inject her own insulin. However; on December 25, 2013, the client was not herself. ULP-F stated the C1 took the pen and did not know what to do with it. ULP-F stated that C1 tried to put the pen into her mouth. The client also needed assist to take oral medications as they fell out of the client's mouth. ULP-F stated she was instructed by registered nurse (RN) H, to dial the client's insulin pen and inject the insulin. ULP-F stated she had not been trained to dial a dose on an insulin pen nor had she received training in how to inject insulin. ULP-F stated RN-H instructed them to not send the client to the hospital unless she was unconscious. When interviewed on January 30, 2014, RN-H verified she was the on call nurse and verified she had instructed ULP-F to dial the insulin pen and to inject the insulin. RN-H verified she did not complete an assessment of the client's change in condition. C5 had blood sugars greater than 600. The client's record lacked instructions for the ULPs in regards to blood sugars and lacked assessments from the RN. C5 was admitted for services on January 14, 2006, with diagnoses that included diabetes mellitus and hypertension. The ISP Assessment/Summary dated January 11, 2013, identified the client received daily accuchecks and staff assistance with medication which included prefilled insulin syringes by the RN.	0 030		

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0 030	Continued From page 4 Current physician orders included 1). Check blood sugars three times daily at 7 a.m., noon, and 5:00 p.m., Lantus Insulin 40 units every a.m., and Lantus Insulin 10 units every p.m. In addition the client had an order for glipizide ER (antidiabetic) 10 mg two tablets every a.m. On November 28, 2013, the ULP documented in the Resident Log that the client's blood sugar at 4:00 p.m., was over 600. The documentation indicated the ULP rechecked the client's blood sugar at 8:00 p.m, and it was still over 600. The documentation indicated the on call nurse was notified at this time. The ULP was instructed to call the clients family. The documentation indicated the family instructed staff to transport the client to the hospital. The Urgent Care documentation identified C1 was treated for hyperglycemia (elevated blood sugar). The discharge instructions included directions to contact the doctor if the blood sugar was greater than 300. The discharge instructions included; "If your blood sugar is over 300, and you can't reach your doctor, call or return to this facility." The perimeter of what to do when the blood sugar was greater than 300 was not identified on the MAR. When interviewed on January 30, 2014, RN-H verified there were no instructions for the ULPs to follow when a client has blood glucose readings out of the normal perimeter. RN-H verified she had not completed an assessment of C5's blood glucose readings. C6 had physician orders for blood glucose monitoring two times a day with instructions to notify the physician for readings of less than 80 or more than 300.	0 030		

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0 030	Continued From page 5 The January 2014 MAR identified that on January 29, 2014, the client's blood sugar was 335 for the evening check and on January 30, 2014, C6's blood sugar was 363 on the evening check. When interviewed on January 31, 2014, ULP-C reviewed blood glucose readings. ULP-C described C6 as a "bouncer" when the blood sugars were reviewed. ULP-C stated "I don't know why the machine does that". The client's record lacked documentation that the elevated blood glucose readings were reported to the physician. When interviewed on January 31, 2014, RN-H verified there was no documentation that supported the physician was notified. RN-H verified she was not aware of the elevated blood glucose readings. RN-H verified there was no training provided for diabetic monitoring. The ULP's are trained on how to perform the blood glucose test, but were not provided training on what the test meant. The RN stated she posted hyperglycemic and hypoglycemic posters on the wall in the medication room as a reference for the unlicensed staff. Change in condition C2 had a change in mobility and expressed pain. The client was transported to the hospital and was diagnosed with a fracture of the left knee. The client's record lacked evidence of documentation that an assessment was completed by the RN. The Resident Log documentation dated August 9, 2013, and completed by the ULP identified that C2 was transported to the emergency room at around 10:00 a.m., due to a lump on her knee	0 030		

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0 030	Continued From page 6 and in "a lot of pain." When interviewed on January 31, 2014, ULP-F stated the change in the client's mobility and pain were reported to RN-H right away in the morning. ULP-C stated the RN's response was that the client had osteoporosis. ULP-F stated the client was in a lot of pain and it was more than osteoporosis. On August 9, 2013, at 8:45 a.m., RN-H documented on the Consultant Communication Log that the client's family was notified of the client's complaint of pain in the left knee and that the client would not bear wt. There was no documentation that an assessment was completed. When interviewed on January 31, 2014, RN-H verified she contacted the family when staff reported the change in the client's mobility and expression of pain. RN-H could not recall if an assessment was done. RN-H verified the client was diagnosed with a fractured left knee. C4 lacked an assessment from the RN following falls. The client fell on January 6, 2014, and sustained a fractured hip. The client record revealed that on December 26, 2013, C4 was diagnosed with a urinary tract infection (UTI) and bronchitis. The Resident Log documentation completed by the ULP's indicated the client had consistently refused meals, complained of pain and was weak. A Resident Event Report dated December 29, 2013, identified C4 was found on the floor at 7:30 a.m. The report identified the RN was notified and directions were given to administer pain	0 030		

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0 030	Continued From page 7 medication for the complaint of rib pain. There was no evidence of documentation that an assessment was completed by the RN of the fall. A Resident Event Report dated January 1, 2014, identified C4 was found on the floor at 7:25 a.m. The report identified the housing manager and the RN was notified. The instructions from the RN were to call the family and check the clients vital signs. There was no evidence of documentation that an assessment was completed by the RN of the fall. The documentation by the ULP on the Resident Log continued to indicate the client was refusing meals and was weak. On January 5, 2014, at 5:30 p.m., a Team Member Concern Regarding a Resident form was completed by an ULP. This form was sent to the RN and contained the following information: "While walking down to supper (name) complained of her left breast area and rib area hurting again tonight. she said she was also dizzy and almost fell 2 times so staff had her sit on her walker chair seat and took her the rest of the way. She stated it hurt when she took a big breathe". The RN's response (no date or time) was; "Give her Tramadol as ordered for pain. She is not eating or drinking well. She is weak and dizzy from this." A Resident Event Report dated January 6, 2014, at 12:35 a.m., identified C4 was found on the floor. The client complained of left hip pain, and was transferred to the hospital where she was diagnosed with a fractured left hip. When interviewed on January 31, 2014, RN-H verified there were no assessments completed following the falls on December 29, 2013, or on January 1, 2014. RN-H verified there were no	0 030		

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(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) COMPLETE DATE
0 030	Continued From page 8 revisions or new interventions implemented to minimize C4's risk for falls. C5 exhibited signs and symptoms of a yeast infection for greater than one month before treatment was provided. On December 3, 3013, at 8:30 p.m. a ULP completed a Team Member Concern Regarding a Resident form that identified C5 took lotion and rubbed in her vagina stating it was sore and burning. The documentation identified that C5 voiced to the ULP that the lotion helped. The response from the RN (no date or time) directed the ULP staff to; "Use cream in orange and white tube." On December 25, 2013, at 7:30 p.m., a Team Member Concern Regarding a Resident form was completed that identified the following: "While using the bathroom (name) put hand lotion on her vagina and said I am so sore. Staff told her using hand lotion was not a good thing and tried to get her to wash with a wash cloth". The RN response (no date or time) was: "New cream given to her to apply." There was no documentation of what cream or how often the cream should be applied. On January 19, 2014, the client was seen at urgent care. The client was diagnosed with vaginitis and orders were received for treatment. When interviewed on January 31, 2014, RN-H verified she was made aware of the client's symptoms of vaginal soreness. RN-H verified there were no assessments documented, and no physician notification of the signs and symptoms that C5 exhibited. TIME PERIOD FOR CORRECTION: Thirty (30)	0 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20449	A. BUILDING: _____ B. WING _____	C 02/14/2014

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0 030	Continued From page 9 days	0 030		
0 605	626.557 Subd.3 Timing of report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	0 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20449	A. BUILDING: _____ B. WING _____	C 02/14/2014

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0 605	Continued From page 10 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an injury that could not be reasonably explained was reported to the common entry point (CEP) for one of one client in the sample who sustained a fracture. The findings include: C2 had a change in mobility and expressed pain when morning cares were provided on August 9, 2013. The client was transported to the hospital and diagnosed with a fracture of the left knee.	0 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20449	A. BUILDING: _____ B. WING _____	C 02/14/2014

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0 605	Continued From page 11 The licensee's policy and procedure Caregiver Misconduct and Vulnerable Adults identified an injury of unknown source by Federal and State definition; however the definition was for the state of Wisconsin. The information in the procedure did not address reporting injuries that could not be reasonably explained to the common entry point (CEP) When interviewed on January 31, 2014, RN-H verified there was no documentation that could explain the fracture that C2 sustained. RN-H verified a report was not made to CEP. The RN stated "I didn't know I had to." TIME PERIOD FOR CORRECTION: Thirty (30) days	0 605		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up
PUBLIC DATA

Facility:
KSMS Our House LLC
204 14th Street Northwest
Austin, MN 55912
Mower County

Report #: HL20449014

Date: June 18, 2014

Date of Visit: June 13, 2014
Time of Visit: 10:40 a.m.

By: Karen Johnson, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up two state licensing order(s) which were issued on February 28, 2014, as the result of an investigation which had been completed on February 14, 2014.

The status of each order is as follows:
1 144A.44 Subd.1(2) - Corrected
2 626.557 Subd. 3 - Corrected

xc: Minnesota Department of Health – Licensing and Certification

AH Form Approved
6/18/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H20449	A. Building B. Wing	6/13/2014

Name of Facility	Street Address, City, State, Zip Code
KSMS OUR HOUSE LLC	204 14TH STREET NORTHWEST AUSTIN, MN 55912

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 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 06/13/2014	ID Prefix 00605 Reg. # 626.557 Subd.3 LSC	Correction Completed 06/13/2014	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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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:

Followup to Survey Completed on:
2/14/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO