

# Office of Health Facility Complaints Investigative Report

Facility Name: KSMS Our House LLC		Report Number: HL20449017	Date of Visit: September 28, 2016		
Facility Address: 204 14th Street NW			<b>Time of Visit:</b> 9:00 a.m 5:00 p.m.	Date Concluded: February 13, 2017	
Facility City: Austin			Investigator's Name and Title: Debora Palmer, RN, Special Investigator		
State: Minnesota	<b>ZIP:</b> 55912	County: Mower	—— Kathy Smith, RN, Specia	Investigator	

#### Allegation(s):

It is alleged that a client was neglected when s/he presented to the hospital with an elevated temperature, a leg severely bruised with blisters, and a large ulcerated sore on his/her tailbone that was infected.

- State Statutes for Home Care Providers (MN Statutes, section 144A.43 144A.483)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

#### Conclusion:

Based on a preponderance of evidence, neglect occurred when the facility failed to provide proper care and treatment of the client's coccyx, buttock, and heel wounds. The client had recurrent problems with wound healing for over two years. The facility Registered Nurse (RN) failed to provide adequate wound assessment and monitoring of the client's wounds, and failed to provide direction and training to direct care staff who were performing the delegated nursing task of wound care.

The client was cognitively impaired and was completely reliant on caregivers for all activities of daily living. The client could not walk and was transferred by two staff with a mechanical lift. The client was incontinent of bowel and bladder and staff performed the client's incontinence care. The client had pressure sores on the coccyx and left heel for over two years. Direct care staff performed the client's daily wound treatments, without any written instructions or training by the RN.

The client's only wound assessment by the facility RN was completed in 2014. At that time, the client had a stage II pressure ulcer on the inside of the right buttock measuring 2 centimeters (cm)  $\times$  1.5 cm. There was no evidence of further RN oversight of the client's wound. The client's medical record was void of any wound assessments pertaining to the client's heel ulcer.

In March 2016, a hospital record indicated that client still had the stage II pressure ulcer on the right buttock and had also developed a stage II pressure ulcer on the sacrum. Discharge orders to the facility included instructions for dressing changes and instructions to frequently change the client's position.

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In May 2016, direct care staff documented that the client had a "big open sore on her bottom" and the client's family member took the client to the hospital for evaluation. A culture of the wound drainage was taken. Hospital discharge orders provided to the facility included instructions for dressing changes, including the application of an antibiotic ointment for ten days.

In July 2016, a hospital record indicated that the client had multiple areas of dermis loss on the buttocks and inner groin, including a  $4.5~\rm cm~x~0.7~cm$  open lesion on the left inner groin, a  $3.5~\rm x~2.0~cm$  open ulceration on the right lower buttock, a  $4.5~\rm cm~x~2.0~cm$  open ulceration on the right upper buttock, a  $0.3~\rm cm~x~5.0~cm$  open ulceration on the gluteal fold, and two open areas on the left buttock measuring  $0.5~\rm cm~x~0.5~cm$  and  $0.5~\rm cm~x~0.8~cm$ . All areas were macerated. Hospital discharge orders were provided to the facility including instructions for wound care, perineal care, and to document the client's wound healing each day.

In August 2016, a hospital record indicated that the client had an unstageable ulcer on the left heel and the client was admitted for hospitalization due to osteomyelitis of the heel wound with culture results positive for MRSA and Strep. The client underwent a surgical limb salvage procedure for the left heel. The client's buttock and groin wounds were also evaluated during hospitalization. Hospital discharge orders provided to the facility included instructions for wound treatment and care of the surgical incision, which entailed application of an ace wrap to the client's left leg.

In September 2016, a hospital record indicated that the client was emergently hospitalized due to a change in condition. On hospital arrival, the client was unresponsive, had a fever of 101 degrees, oxygen saturations not above 87% on six liters of oxygen, bilateral blue feet, and a left lower leg that was red and swollen with fluid-filled blisters. The client was admitted to the ICU with polymicrobial infections of the left leg, sacrum, and urinary tract, along with pneumonia. The client's condition did not improve with volume resuscitation and broad-spectrum antibiotics. Comfort measures were elected and the client was discharged to a skilled care facility on hospice care.

All of the client's hospital visits from March 2016 to September 2016 were facilitated by the client's family member, based on reports direct care staff gave the family member about the deteriorating condition of the client's wounds. During the same time period from March 2016 to September 2016, multiple direct care staff had informed the RN that the client's wounds were worsening, looked infected, and had drainage that soaked through the dressings. There was no evidence that the RN ever assessed the client's wounds, monitored the status of the client's wounds for healing, or followed up on the culture results. The client's medical record was void of any wound assessments from March 2016 to September 2016 and void of any progress notes or evidence of follow-up about the client's wound culture. During the period March 2016 to September 2016, direct care staff performed the client's wound dressings, without any evidence of training by the RN including the safe handling of contaminated materials. The client's care plan completed by the RN did not contain any information about the client's wounds.

After the client had the left heel surgical procedure in August 2016, hospital discharge instructions included application of an ace wrap to the client's left leg following incision care. Only the RN applied the client's ace

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wrap. There was no evidence that the RN monitored the client's left leg for circulation, motor ability, or sensation. When the client was re-hospitalized in September 2016, the hospital record noted that the client's left lower leg had "an ace wrap that was bound too tightly" causing the appearance of "rug-burns," in addition to an obvious cellulitis of the lower extremity which was red and swollen with fluid-filled blisters.

When interviewed, the facility RN had no explanation regarding the inadequate nurse oversight of the client's wounds.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

<del></del>		
Substantiated     ■	☐ Not Substantiated	☐ Inconclusive based on the following information:

# 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 is responsible for the neglect. The facility lacked policies and procedures that defined the role and responsibilities of the RN. Facility leadership failed to ensure the RN was accountable for proper nursing care to clients.

The RN is also responsible for the neglect. The client's wounds deteriorated and the RN failed to assess or monitor the client's wounds according to basic principles of nursing practice. The RN delegated the nursing task of wound care to direct care staff without training the direct care staff in the procedure for wound care or overseeing that wound care was properly completed by direct care staff, including the handling of contaminated wound materials.

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 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.

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 & 144A were not met.

State licensing orders were issued: Yes No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Facility Corrective Action:

The facility took the following corrective action(s):

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## Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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- (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

Facility Name: KSMS Our House LLC Report Number: HL20449017 maltreatment occurred. The Investigation included the following: <u>Document Review</u>: The following records were reviewed during the investigation: **Medical Records** Care Guide Medication Administration Records **Nurses Notes** X Assessments Physician Orders Treatment Sheets **Physician Progress Notes** Care Plan Records X Skin Assessments **Facility Incident Reports** Service Plan Other pertinent medical records: ▼ Hospital Records Additional facility records: Staff Time Sheets, Schedules, etc. Facility Internal Investigation Reports Personnel Records/Background Check, etc. X Facility In-service Records **Facility Policies and Procedures** Number of additional resident(s) reviewed: Eight Were residents selected based on the allegation(s)? Yes O No  $\bigcirc$  N/A Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes

No

 $\bigcirc$  N/A

Specify: The client was discharged to a skilled care facility.

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Interviews: T	The following into	erviews were cond	lucted during the	e investigation;	
	h complainant(s)				
Specify:					· ,
If unable to co	ontact complainar	nt, attempts were	made on:		·
Date:	Time:	Date:	Time:	Date:	Time:
Interview wit	h family:   Yes	No	/A Specify:		
Did you interv	view the resident(	s) identified in alle	egation:		
○ Yes •	No 🔿 N/A S	pecify: The client	was discharged.		
Did you interv	view additional re	sidents? • Yes	○ No		
Total number	r of resident interv	views:Seven			
Interview witl	h staff:   Yes	○ No ○ N/A	Specify:	No. 19 April	
Tennessen W	<sup>/</sup> arnings				
	arning given as re	•	○ No		
Total number	of staff interview	s: Eight			
Physician Inte	rviewed: OYes	<ul><li>No</li></ul>			
Nurse Practiti	oner Interviewed	Yes <b>●</b> N	lo		
Physician Assi	istant Interviewed	: ○Yes • N	lo		
Interview with	h Alleged Perpetra	ntor(s): O Yes	○ No ● N/A	Specify:	
Attempts to c	ontact:				
Date:	Time:	Date:	Time:	Date:	Time:
If unable to co	ontact was subpoe	ena issued: O Yes	s, date subpoena	was issued	
Were contact:	s made with any c	of the following:	*		•
☐ Emergen	cy Personnel 🔲	Police Officers	☐ Medical Exam	iner 🔲 Other: S	Specify

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Obse	rvations were conducted related to:
X	Personal Care
X	Nursing Services
x l	Jse of Equipment
<b>X</b> (	Cleanliness
X [	Dignity/Privacy Issues
X S	Safety Issues
X F	acility Tour
Was e	equipment inspected:  Yes  No  N/A equipment being operated in safe manner:  Yes  No  N/A photographs taken:  Yes  No  Specify:
cc:	
Healt	h Regulation Division - Home Care & Assisted Living Program
Minne	esota Board of Nursing
The O	ffice of Ombudsman for Long-Term Care
Austir	n Police Department
Mowe	er County Attorney
Austir	n City Attorney

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
		H20449	B. WING		_	) 9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1.000	
KSMS O	UR HOUSE LLC		STREET NO MN 55912	DRTHWEST		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETE DATE
0 000	Initial Comments		0 000			
	****ATTENTION****	•		·		
	HOME CARE PRO	VIDER LICENSING ORDER				
In accordance with Minnesota Statutes section 144A.43 to 144A.482, this correction order (s) has been issued pursuant to a survey.						
	initiated to investiga and #HL20449017. there were 79 client	laint investigations were te Complaints #HL20449016 At the time of the survey, s that were receiving services ensive license. The following e issued:				
0 325 SS=G	144A.44, Subd. 1(1	4) Free From Maltreatment	0 325			
	receives home care (14) the right to be f abuse, neglect, fina forms of maltreatment cov	ment of rights. A person who services has these rights: ree from physical and verbal ncial exploitation, and all rered under the Vulnerable Maltreatment of Minors Act;			İ	
	by:	ent is not met as evidenced and document review, the				
	facility failed to ensuneglect when the fa	ure that clients were free from cility failed to assess or s reviewed (C1 and C2) who				
	hospitalization. C1 f not assessed or mo though C1 exhibited	ell and broke her leg and was nitored by the RN even symptoms of fracture for ten recover during hospitalization				
	and was discharged condition to a skilled	from the hospital in guarded care facility to receive clined with symptoms of				

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION :	(X3) DATE	SURVEY
			A. BOILDING		C	
		H20449	B. WING			9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I		DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 325	Continued From pa	ge 1	0 325			
	monitor; C2 could r hospitalization and	at the RN did not assess or not recover during was discharged from the care facility to receive hospice				
	Findings include:					
		Il risk assessment, dated that C1 was at high risk for				
	indicated that C1 no confined to a wheel with her feet. C1 ne staff to stand and p unsteadiness when and history of falls. one staff for all activerbally express he alone in her apartm	sment, dated 01/12/16, o longer ambulated. C1 was chair which C1 could propel eded the assistance of one ivot for transfers, due to C1's standing, balance problems, C1 needed the assistance of vities of daily living. C1 could r needs and desires. C1 lived ent and wore a pendant that lert staff when she needed				
	(Saturday) at 3:45 a staff because she h Resident Care Assist found C1 sitting on wheelchair. C1 told when she fell, but si another staff assiste immediately notified home that C1 had fa	eport, dated 07/23/16 a.m., indicated that C1 paged ad fallen in her apartment. stant (RCA)/G responded and the floor next to the RCA/G that she hit her knees he was "alright." RCA/G and ed C1 off the floor. Staff I House Manager (HM)/C at allen. The RN on-call was at 10:00 a.m. on 07/23/16.				
	that C1 was assess	23/16, there was no evidence ed by a nurse at any time. nce that the RN on-call for the				

PRINTED: 12/12/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ C B. WING H20449 12/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **204 14TH STREET NORTHWEST** KSMS OUR HOUSE LLC **AUSTIN, MN 55912** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 Continued From page 2 0 325 weekend of 07/23/16 - 7/24/16 ever checked C1 for potential injuries. A progress note on 07/25/16 indicated that RN/B spoke to C1 on 07/25/16 about how she was feeling since the fall of 07/23/16 and C1 did not report any complaints of pain anywhere. There was no evidence that RN/B thoroughly assessed C1 for any potential injuries or examined C1's knees, even though C1 had told staff that she hit her knees during the fall. There was no evidence of any further nursing follow-up of C1's status until 08/02/16, at which time a progress note by RN/B indicated that C1 was complaining of soreness in the right knee. RN/B documented that C1's right knee was "bruised and swollen" but the degree, character, extent, and location of bruising and swelling was not indicated. There was no evidence that RN/B assessed C1's degree of pain or how it impacted C1's activities of daily living. There was no evidence that RN/B evaluated C1's transfer mode for continued appropriateness to stand and pivot. A progress note written by unlicensed staff on 08/03/16 indicated that unlicensed staff had filled out a Concern Form for RN/B about the pain C1 was having in her right leg. There was no evidence of any follow-up by RN/B. C1's hospital record indicated that C1's family members took C1 to the emergency department (ED) on 08/03/16 at 4:40 p.m. due to severe pain in her right leg. C1 told ED staff that she tripped

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and fell to the floor on both knees over a week ago. On examination, C1 had severe pain with movement and position changes of the right leg. and decreased range of motion in the right knee. C1's right and left anterior knees had diffuse bruising with greater bruising on the right lateral tibia, right upper arm, and right breast. C1's right

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			?
		H20449	B. WING			9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC		STREET NO	DRTHWEST		
(٧4) 10	SUMMARY STA	AUSTIN, N	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE
0 325	was suspicious for C1 had a right tibia managed conservate the cellulitis w During hospitalizati kidney injury and al 08/10/16, C1 was of facility in guarded chospice care.  An interview was conserved to C1's RCA/G found C1 si buttocks by her reconstruction of C1 said she was son RCA/G and RCA/H recliner by standing recliner. RCA/G the notified HM/C that does not end until 7 gets C1 dressed in of 07/23/16, C1 said RCA/G helped C1 that days, RCA/G observing the gright arm, time, C1 complained C1 was sitting in the RCA/G performed that week. RCA/G to change C1's transchanges in C1's us An interview was considered that week and the changes in C1's us an interview was considered to C1/23/16 and was it red in color. C1 was red in c1	en, and warm to touch which cellulitis. X-rays confirmed that I plateau fracture which was stively. C1 was hospitalized to ith intravenous antibiotics. on, C1 declined with acute tered mental status. On discharged to a skilled care condition with a plan for enducted with RCA/G on m. RCA/G stated she page at 3:45 a.m. on 07/23/16. Itting on the floor on her liner, where C1 often sleeps. One and her right leg hurt. I transferred C1 back into the group of the called HM/C at home and C1 had fallen. RCA/G's shift 7:00 a.m. and RCA/G routinely the mornings. On the morning do her right leg hurt when to dress. After a couple of envel purple bruises on C1's and right breast. During this and of pain in the right leg when the recliner and during transfers. C1's care several more times was never directed by anyone asfer mode or make any	0 325			

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H20449    B. WING		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE	
H20449   B.WING   12/09/2016	AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES   DEACH CONTINUED   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION CEACH COMPLETE TAGE)   SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DAVE)			H20449	B. WING			
(X4) ID (CAL) ID (CACH DESCRICT OF DEFICIENCIES (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 325  Continued From page 4 agreeable to care because she was in pain. C1 complained daily that both of her legs hurt. C1 normally wore TED stockings because it hurt when staff applied them. C1 also complained of shoulder pain. When clients experience a problem, RCAs are supposed to fill out a Concern Form for RN/B so RN/B can follow-up on the client concern. RCA/H completed numerous electronic concerns forms about C1's pain and discolored legs. Prior to the interview with the OHFC investigator, RCA/H checked the computer to read the Concern Forms she previously entered and submitted to RN/B about the problems C1 was having after the 07/23/16 fail. All of the Concern Forms and notes that RCA/H entered into the computer had been deleted.  An interview was conducted with HM/C on 10/26/16 at 7:03 a.m. HM/C stated she got called in the middle of the night on 07/23/16 (Saturday) that C1 had fallen in her apartment. Staff reported that C1's leg was red and sore but C1 didn't want to go to the hospital to have it evaluated. On 07/25/16 (Monday), RN/B received the Event Report from unlicensed staff about C1's fall during the night of 07/23/16, RN/B shares an	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 325  Continued From page 4  agreeable to care because she was in pain. C1 complained daily that both of her legs hurt. C1 normally wore TED stockings but after C1 fell on 07/23/16, C1 refused to wear the TED stockings because it hurt when staff applied them. C1 also complained of shoulder pain. When clients experience a problem, RCAs are supposed to fill out a Concern Form for RNJB so RNJB can follow-up on the client concerns. RCA/H completed numerous electronic concerns forms about C1's pain and discolored legs. Prior to the interview with the OHFC investigator, RCA/H checked the computer to read the Concern Forms she previously entered and submitted to RNJB about the problems C1 was having after the 07/23/16 fall. All of the Concern Forms and notes that RCA/H entered into the computer had been deleted.  An interview was conducted with HM/C on 10/26/16 at 7:03 a.m. HM/C stated she got called in the middle of the night on 07/23/16 (Saturday) that C1 had fallen in her apartment. Staff reported that C1's leg was red and sore but C1 didn't want to go to the hospital to have it evaluated. On 07/25/16 (Monday), RN/B received the Event Report from unlicensed staff about C1's fall during the night of 07/23/16. RN/B shares an	KSMS O	UR HOUSE LLC			PRTHWEST		
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office with HM/C. HM/C observed RN/B complete the nurse's section of C1's Event Report at her desk in the office, without checking C1. On 07/27/16, HM/C observed an electronic Concern Form completed by RCA/G that indicated C1's leg was purple and sore. Later in the week, HM/C observed a couple other electronic Concern Forms from staff noting that C1's leg hurt and C1 was having difficulty with transfers. HM/C did not know whether RN/B had assessed C1 at any time. HM/C checked the electronic record throughout the week and there was nothing	0 325	agreeable to care is complained daily the normally wore TED 07/23/16, C1 refuse because it hurt whe complained of show experience a proble out a Concern Form follow-up on the clienumerous electronipain and discolored with the OHFC invecomputer to read the problems C1 with the Problems C1 with the Gall. All of the Concern RCA/H entered into deleted.  An interview was considered at the problems C1 with the middle of the that C1 had fallen in that C1's leg was reto go to the hospita 07/25/16 (Monday). Report from unlicer during the night of confice with HM/C. He had the nurse's section desk in the office, wor/27/16, HM/C observed a couple Form from staff now whether RN/E time. HM/C checked	pecause she was in pain. C1 at both of her legs hurt. C1 stockings but after C1 fell on ed to wear the TED stockings en staff applied them. C1 also alder pain. When clients em, RCAs are supposed to fill in for RN/B so RN/B can ent concern. RCA/H completed in concerns forms about C1's allegs. Prior to the interview estigator, RCA/H checked the ne Concern Forms she and submitted to RN/B about as having after the 07/23/16 ern Forms and notes that in the computer had been enducted with HM/C on enducted with enducted. On enducted with enducted	0 325			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING			
		H20449	B. WING	-	12/0	) 9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	STREET NO NN 55912	DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 325	documented by RN status. RN/B did en 08/22/16, after the and requested recc 07/23/16 fall. At that computer for the elihad been complete Concern Forms we their contents had right which concerned H HM/C has observe or delete them from An interview was concerned to 10/05/16 at 9:16 a. C1's care during the 07/23/16. Normally wheelchair with her the dining room for legs hurt and C1 cowith her feet. C1 as dining room for meanire right side had extended from C1's breast. Day by day, from purple to red awas still standing an toilet. RCA/E assist times that week and when she stood on Concern Form to R RCA/E did not know RN/B never advised transfer mode.  Family member (FN 10/06/16 at 2:20 p.ron 07/31/16. C1 waright knee. C1 said	/B pertaining to C1's fall or other some progress notes on State agency called the facility ords pertaining to C1's at time, HM/C checked the ectronic Concern Forms that d by the RCA staff. The re absent in the computer and not been printed or saved M/C. On other occasions, and RN/B rip up Concern Forms	0 325			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		Hoodan	B. WING	•		C
		H20449			] 12/	09/2016
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
KSMS O	UR HOUSE LLC		STREET NO MN 55912	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
0 325	pushing her wheeled C1 wouldn't allow is said the leg was breat family member abovisited C1 a couple hospital to have he learned that C1's riendured a broken intervention.  Interviews were co at 9:05 a.m., 10:58 stated she works for this location. The nurses who are onnot onsite at the fa and oversee all clie problems that have after C1 fell on 07/2 and swelling to the all week without an pivoting. When C1 the right leg, C1's femergency room of she received multipunlicensed staff respain, bruising, and not know how man assessed, or monif 07/23/16 - 08/04/16 progressively wors time. RN/B made co (07/25/16 and 08/00 detailed assessment.)	it hurt her leg so the staff were chair to the dining room for her. FM/I to look at her leg but C1 uised. FM/I contacted another out C1's statements, who days later and took C1 to the er leg evaluated. Family then ight leg was broken. C1 had eg for ten days with no a.m., and 4:30 p.m. RN/B ull time at the facility Monday I/B is the only nurse employed he agency employs two other call during hours that RN/B is cility. RN/B's role is to direct ent care and follow-up on client expected and complaining of pain in amily member took C1 to the in 08/03/16. RN/B denied that ole Concern Forms from garding C1's symptoms of mobility difficulties. RN/B did y times she observed, fored C1's status from 6 or if C1's symptoms ened during that period of only two brief progress notes 12/16) which did not include any not information.				
Minnesota D		unlicensed staff to assess the range of motion: "Assess the				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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		H20449	B. WING	PAL - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1	12/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
KSMS C	UR HOUSE LLC	204 14TH AUSTIN, N	STREET NO IN 55912	PRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 325	resident and provid and perform range is an injury. Be care resident. Contact D report the situation. is safe to move the will be able to do so the residentCompfacility's policy did in pertaining to the resident pertaining to the resident post-fall.  The facility did not if the role or responsi policy on Resident I responsibilty for assunlicensed staff.  C2's nursing assess 06/16/16, indicated impaired and compall activities of daily and was unable to stransferred by two sa pressure-relieving night. C2 was incomby staff every four his skin barrier cream a incontinence. Staff as ordered by C2's nursing assessmen whether C2 had any C2's only Skin and	e First Aid. Take vital signs of motion to determine if there eful not to further injure the irector or person on-call to If it is determined that that it resident, assess whether you without injury to yourself or olete the Event Report." The tot include information sponsibilities of the licensed ents after falls and conduct be of the client's status.  The facility's Falls inappropriately assigned sessment of client injury to sement and plan of care, dated that C2 was cognitively letely reliant on care givers for living. C2 could not ambulate stand for transfers. C2 was staff with a hoyer lift. C2 wore in boot on her left foot each tinent and was to be toileted fours. Staff were to apply a fafter each episode of were to "treat any open area doctor," but neither the tour the care plan specified	0 325			

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PRINTED: 12/12/2016 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING H20449 12/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 204 14TH STREET NORTHWEST KSMS OUR HOUSE LLC **AUSTIN. MN 55912** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 Continued From page 8 0 325 include any further wound assessments or nursing progress notes about status of C2's Stage II pressure ulcer on the right buttock, until a hospital discharge summary dated 03/10/16 indicated that C2 had Stage II pressure ulcers on the sacrum and right gluteus (measurements not documented). The hospital discharge summary indicated that facility staff needed to change C2's positions frequently and apply Mepilex dressings to the ulcers. There was no information on C2's care plan regarding C2's pressure ulcers, need for Mepliex dressings, or need for frequent position changes to redistribute pressure. There was no evidence of RN assessment or follow-up of C2's wounds. A Concern Form completed by unlicensed staff on 05/25/16 indicated that C2 had a "big open sore on her bottom." C2 was sent to the clinic on 05/25/16. The clinic provider documented that a wound culture was obtained from C2's left buttock decubitus ulcer. Facility staff were to apply an ointment three times daily for 10 days and follow up with a wound clinic. There was no evidence of RN assessment of C2's wounds or follow-up monitoring of C2's wounds by the RN. There was no information in C2's medical record regarding the wound culture results or whether C2's ulcers were evaluated by a wound clinic.

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C2's hospital record. dated 07/14/16, indicated that C2 was seen in the emergency department for multiple areas of dermis loss on the buttocks and inner groin, including a 4.5 cm x 0.7 cm open lesion on the left inner groin, a 3.5 cm x 2.0 cm open ulceration on the right lower buttock, a 4.5 cm x 2.0 cm open ulceration on the right upper buttock, a 0.3 cm x 5.0 cm open ulceration on the gluteal fold, and two open ulcerations on the left

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		H20449	B. WING		12/0	9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, M	STREET NO NN 55912	DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 325	buttock measuring 0.8 cm. All areas we culture was obtained discharge orders in C2's perineal care at that was to be provided to change of and offload pressur ordered Mepilex drand inner groin and were to "assess for C2's facility medicanursing assessment progress notes performed wounds. There was plan regarding C2's C2's hospital record that C2 was seen in for an unstageable admitted for hospitating the heel wound, with MRSA and Strep. Calcanectomy (a sure on 08/06/16. C2 was for 13 days. During and groin wounds we specific wound treat discharged back to physician's orders for C2's buttock ulcers.  There was no evided C2 upon facility readid not include any nursing progress no C2's medical record.	0.5 cm x 0.5 cm and a 0.5 x vere macerated. A wound of. The hospital physician's cluded a specific protocol for and incontinence management ided by facility staff. The locumented that facility staff C2's position every two hours re. The hospital physician essings to the buttock ulcers documented that facility staff healing each day."  I record did not include any the of C2's skin or any nursing raining to C2's skin status or an information on C2's care	0 325	DELIGITY		

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING H20449 12/09/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KSMS OUR HOUSE LLC 204 14TH S AUSTIN, MI		H STREET NORTHWEST MN 55912		
(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
0 325	Continued From page 10	0 325		
	buttock wounds.			
	C2 was re-hospitalized on 09/07/16. C2's facility medical record was void of any nursing progress notes from 08/03/16 to 09/07/16 or any indication as to why C2 had to be hospitalized on 09/07/16.	ר   ר		
	C2's hospital record, dated 09/07/16, indicated that C2 presented to the emergency department by ambulance, after family called 911 due to C2's unresponsive state. On hospital arrival, C2's eye were open but C2 was not responding to any stimuli. C2 had a fever of 101 degrees with oxygen saturations not above 87% on 6 liters of oxygen. Both of C2's feet were blue. C2's left lower leg was red and swollen with fluid-filled blisters, with an ace wrap that was bound too tightly causing the appearance of "rug-burns," in addition to an obvious cellulitis. C2's sacral ulcer had deteriorated since previous hospitalization o 08/03/16. C2 was admitted to the ICU with polymicrobial infections of the left leg, sacrum, urinary tract, and pneumonia. C2's condition did not improve with volume resuscitation and broad-spectrum antibiotics. Comfort measures were elected and C2 was discharged to a skilled	s s		
	care facility on 09/09/16 to receive hospice care. An interview was conducted with RCA/D on 10/05/16 at 8:32 a.m. RCA/D stated C2 had a big sore on her tailbone for a long time and a rash over her entire buttocks. C2 also had a sore on her heel for over two years that would start to ge better then recur again. The RCA staff covered C2's tailbone sore with a Mepilex dressing, which was checked several times a day in connection with C2's incontinence care. If the Mepliex dressing was wet from urine, RCA staff would re-apply a fresh one. RCA staff also applied a Mepilex dressing to C2's left heel sore and then	g t		
Minnesota De	re-apply a fresh one. RCA staff also applied a Mepilex dressing to C2's left heel sore and then epartment of Health			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		H20449	B. WING		12/09/2016		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
KSMS O	UR HOUSE LLC		STREET NO MN 55912	RTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
0 325	wrapped C2's heel then apply C2's "sa how to do the Mepi instructions on the provided any trainin how to perform the pertinent observative regarding the appenever observed RC dressing and RCA/changes for over to RN/B make person wounds but RN/B what C2's sores low what C2's sores low An interview was of 10/05/16 at 7:56 a. performed C2's perhad a "huge" sore of dressing was often RCA/H performed would reapply a ned ressing was wet. apply the Mepilex of any wound care instany observations of technique. During the resided at the facility infected and had "of from it. Eventually of the performed C2's p	with gauze. RCA staff would afety booties." RCA/D learned ilex dressing by following the Mepilex package. RN/B nevering instructions to RCA/D about Mepilex dressing or any ons staff should make the sarance of C2's wounds. RN/B CA/D perform the Mepilex (D did C2's Mepilex dressing wo years. RCA/D never saw and observations of C2's would sometimes ask RCA/D	0 325				

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: \_\_\_\_\_ C B. WING 12/09/2016 H20449 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 204 14TH STREET NORTHWEST KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 0 325 0 325 Continued From page 12 how to change the bandage but RN/B never observed RCA/G's dressing technique and there were no written instructions from RN/B on how to do the dressing change. C2 also had a sore on her heel that kept oozing all over the bed. RCA staff forwarded at least four Concern Forms to RN/B about C2's heel but no instructions or training was ever provided to staff by RN/B. During the last few weeks that C2 resided at the facility. C2 had an ace wrap on her leg and her heel drainage would ooze right through the ace wrap. RCA staff were told not to change the ace wrap. The ace wrap was applied by RN/B only. An interview was conducted with RCA/E on 10/05/16 at 9:16 a.m. RCA/E stated she provided C2's incontinence care many times. C2 had a sore on her tailbone that was the size of "a slice of cheese." The area bled when C2 was wiped. The entire left side of C2's buttock was red and the skin flaked off when perineal care was provided. The bandage that was on C2's tailbone sometimes came off when it was wet from urine. When C2's dressing needed to be reapplied, RCA/E would get another RCA to change the dressing because RCA/E had never been trained on the procedure for dressing changes. RCA/E did fill out a Concern Form about C2's sore bottom and submitted it to RN/B. RCA/E never received any feedback from RN/B. RN/B has never observed RCA/E perform any of the clients' cares or provided RCA/E with any written or verbal information regarding client updates. The only updates RCA/E receives on clients is from other RCAs. An interview was conducted with RCA/F on 10/05/16 at 9:50 a.m. RCA/F stated that C2 had

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sores on her tailbone and on her heel. The RCA staff put Mepilex dressing on both wounds. The

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDFLAN	OF CONNECTION	BENTH IDATION NOMBER.	A. BUILDING:	A. BUILDING:		
		H20449	B. WING		12/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		-,
VCMC O	UD HOUSE LL C	204 14TH	STREET NO	PRTHWEST		
KSWS U	UR HOUSE LLC	AUSTIN, I	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 325	only observe C2's werequested it. At one facility stay, C2 had the heel sore. Only RCA staff were told Interviews were conat 9:05 a.m., 10:58 stated that it is the RN to train unlicens nursing procedures prior to staff perform the RN validates stochange would constask. RN/B had no inadequate nurse of management, inclusted for dressing change acknowledged that who applied C2's accompleted C2's wowny she did not compovement, and servith C2's ace band there was no specific protocol for resident monitoring of client reassessment whe provider appointment. The facility's policy Documentation, review of the provider appointment of the team member whead to toe, noting bruised, dry, red, so	inge 13 In heal then recur. RN/B would wounds when the RCA staff is point toward the end of C2's it an ace wrap on the leg over RN/B applied the ace wrap. In not to do the ace wrap. Inducted with RN/B on 09/28/16 it. The training needs to occur ming the delegated task and aff competency. A dressing explanation regarding explanation regarding oversight of C2's wound ding delegated nursing tasks is on two wounds. RN/B is he was the only employee ce bandage after RCAs und care. RN/B did not know induct CMS (circulation, insation) checks in connection age. RN/B acknowledged that fic nursing practice or facility it assessment, follow-up changes in condition, or client in clients return from medical into or hospitalizations.  On Wound Management and vised 08/27/13, indicated upon discharge from the observation for skin integrity, will check the resident from any skin areas that are cally, tender, open, warm to appearance. Upon	0 325	DLI-IGILNOT)		
		very, the following information				

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: \_\_ C B. WING 12/09/2016 H20449 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 204 14TH STREET NORTHWEST KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 0 325 Continued From page 14 0 325 is required to be charted in the resident's log by the RCA: Location...the Skin and Wound Assessment form is to be completed to note the location: Size - determined by length and width. The use of the Wound Measurement template is required to measure the size of the wound; Pain presence or absence or type of pain may indicate infection, tissue destruction. A Concern Form is to be completed and given to the Director...for immediate response. The Skin and Wound Assessment form and Wound Measurement template are to be stapled to the Concern Form. These forms will be reviewed by the Director daily...the Director is to immediately update the resident's Individual Service Plan regarding the skin concern and include any treatment prescribed by the physician and any steps to prevent further skin concerns from occurring. RCAs are not to administer, clean, bandage, or dress any wounds without a written physician's order. Any area that requires more than basic first aid (band aid and antibiotic ointment) a wound care nurse will be contacted to provide wound care." The facility's policy on Care Plans, dated 02/14/06, indicated "Every six months (starting with the admission date) an assessment and care plan need to be completed. Unless there is a significant change in the resident's condition it should be done at the time of significant change. Care plan needs to be completed means: Assessment and care plan adequately reflects needs/condition of resident...A copy of the care plan needs to be available to staff day of admission and whenever changes occur." Time Period for Correction: Twenty-one (21) days

PRINTED: 12/12/2016 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: \_\_\_ C B. WING H20449 12/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 204 14TH STREET NORTHWEST KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 01080 01080 Continued From page 15 01080 01080 144A.4794, Subd. 3 Contents of Client Record SS=E Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number: (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records: (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the

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client including reporting to the appropriate supervisor or health care professional: (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights;

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_\_ С B. WING H20449 12/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 204 14TH STREET NORTHWEST KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 01080 01080 Continued From page 16 (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and (14) discharge summary, including service termination notice and related documentation, when applicable: and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure that client records contained sufficient information that captured client changes in condition for 4 of 9 clients reviewed (C1, C2, C3, and C4), actions taken in response to client needs for 4 of 9 clients reviewed (C1, C2, C3, and C4), progress regarding client health issues, for 4 of 9 clients reviewed (C1, C2, C3, and C4) and discharge summaries that indicated the reason and client's condition at the time services were terminated for 2 of 9 clients reviewed (C1 and C2). Findings include: C1's nursing assessment, dated 01/12/16, indicated that C1 no longer ambulated. C1 was confined to a wheelchair which C1 could propel with her feet. C1 needed the assistance of one

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staff to stand and pivot for transfers, due to C1's unsteadiness when standing, balance problems, and history of falls. C1 needed the assistance of one staff for all activities of daily living. C1 could verbally express her needs and desires. C1 lived

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_\_ C B. WING H20449 12/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **204 14TH STREET NORTHWEST** KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Continued From page 17 01080 01080 alone in her apartment and wore a pendant that she could push to alert staff when she needed help. A Resident Event Report, dated 07/23/16 (Saturday) at 3:45 a.m., indicated that C1 paged staff because she had fallen in her apartment. Resident Care Assistant (RCA)/G responded and found C1 sitting on the floor next to the wheelchair. C1 told RCA/G that she hit her knees when she fell, but she was "alright." RCA/G and another staff assisted C1 off the floor. After C1 fell on 07/23/16, there was no evidence that C1 was assessed by a nurse at any time. C1's nursing progress notes contained two entries by RN/B, one dated 07/25/16 and another dated 08/02/16. The progress note on 07/25/16 indicated that RN/B spoke to C1 on 07/25/16 about the fall. There was no evidence that RN/B thoroughly assessed C1 for any potential injuries, examined C1 or evaluated C1's mobility status. RN/B made one other progress note on 08/02/16 that indicated C1 was complaining of soreness in the right knee and C1's right knee was "bruised and swollen." C1's nursing progress notes after 08/02/16 were blank. C1's nursing progress notes prior to the entry RN/B made on 07/25/16 were blank. C1 resided at the facility for ten years. Interviews were conducted with RCA/G on 10/05/16 at 7:25 a.m., RCA/E on 10/05/16 at 9:16 a.m., and RCA/H on 10/05/16 at 7:56 a.m. All three staff stated that C1 experienced a change

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in condition after the fall of 07/23/16. RCA/G and RCA/E stated that C1 developed purple bruises on her right leg, right arm, and right breast that later turned red and started swelling. RCA/E

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FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: С B. WING 12/09/2016 H20449 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **204 14TH STREET NORTHWEST** KSMS OUR HOUSE LLC **AUSTIN. MN 55912** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 01080 Continued From page 18 01080 stated that C1 complained of right leg pain when sitting in the recliner and during transfers. RCA/E stated that C1 complained of leg pain when standing during transfers and C1 could not propel the wheelchair with her feet. RCA/H stated that C1 complained of leg and shoulder pain daily and refused to wear her TED hose because it hurt her legs when staff applied them. RCA/G, RCA/E and RCA/H all submitted Concern Forms to RN/B about C1's painful leg, swelling, bruising, difficulty transferring, and changes in mobility status. An interview was conducted with House Manager (HM)/C on 10/26/16 at 7:03 a.m. HM/C verified that she read numerous Concern Forms submitted by RCA staff electronically to RN/B about C1's ongoing issues with leg pain, bruising, and difficulty with transfers after C1 fell on 07/23/16. After the State agency investigation started, HM/C checked the computer and all of the Concern Forms completed by the RCAs regarding C1 were absent in the computer. On prior occasions. HM/C has observed RN/B rip up Concern Forms or delete them from the computer. At the time of the onsite investigation, C1's electronic record did not include any Concern Forms after C1's fall on 07/23/16. There was no evidence that RN/B followed up on C1's problems that had been identified by care givers. C1's family member took C1 to the hospital on 08/03/16 for evaluation of C1's leg pain, where it was determined that C1's right leg was broken. C1's hospital record indicated that C1 further

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plan for hospice care.

declined during hospitalization and was

discharged from the hospital to a skilled nursing facility on 08/10/16 in guarded condition with a

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: \_\_\_ C B. WING H20449 12/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **204 14TH STREET NORTHWEST** KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 01080 01080 Continued From page 19 Interviews were conducted with RN/B on 09/28/16 at 9:05 a.m., 10:58 a.m., and 4:30 p.m. RN/B stated she works full time at the facility Monday through Friday. RN/B is the only nurse employed for this location. RN/B's role is to direct and oversee all client care and follow-up on Concern Forms regarding client problems. RN/B stated that after C1 fell on 07/23/16, C1 had some bruising and swelling to the right knee but C1 transferred all week without any difficulty standing and pivoting. RN/B denied that RCA staff submitted any Concern Forms pertaining to C1. RN/B made two brief progress notes on 07/25/16 and 08/02/16 which did not include any detailed assessment information. RN/B's statement about C1's condition directly conflicted with statements from several caregivers who provided C1's bedside care the week after C1 fell. The discharge summary in C1's facility medical erroneously indicated that C1 was discharged from the facility on 08/08/16 due to hospital transfer, but the discharge summary did not include any information about C1's fall or change in condition after the fall. C2's nursing assessment and plan of care, dated 06/16/16, indicated that C2 was cognitively impaired and completely reliant on care givers for all activities of daily living. C2 could not ambulate and was unable to stand for transfers. C2 was transferred by two staff with a hover lift. C2 wore a pressure-relieving boot on her left foot each night. C2 was incontinent and was to be toileted

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by staff every four hours. Staff were to apply a skin barrier cream after each episode of

incontinence. Staff were to "treat any open area

PRINTED: 12/12/2016 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: C B. WING 12/09/2016 H20449 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **204 14TH STREET NORTHWEST** KSMS OUR HOUSE LLC **AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) Continued From page 20 01080 01080 as ordered by C2's doctor," but neither the nursing assessment nor the care plan specified whether C2 had any open areas. C2's only Skin and Wound Assessment was completed by RN/B over two years ago on 04/03/14, at which time C2 had a Stage II ulcer on the inside edge of the right buttock, measuring 2 cm x 1.5 cm. C2's medical record did not include any further wound assessments or nursing progress notes about status of C2's Stage II pressure ulcer on the right buttock, until a hospital discharge summary dated 03/10/16 indicated that C2 had Stage II pressure ulcers on the sacrum and right gluteus (measurements not documented). The hospital discharge summary indicated that facility staff needed to change C2's positions frequently and apply Mepilex dressings to the ulcers. There was no information on C2's care plan regarding C2's pressure ulcers, need for Mepliex dressings, or need for frequent position changes to redistribute pressure. There was no evidence of RN assessment or follow-up. A Concern Form completed by unlicensed staff on 05/25/16 indicated that C2 had a "big open sore on her bottom." C2 was sent to the clinic on 05/25/16. The clinic provider documented that a wound culture was obtained from C2's left buttock decubitus ulcer. Facility staff were to apply an ointment three times daily for 10 days and follow

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up with a wound clinic. There was no evidence of RN assessment of C2's wounds or follow-up monitoring of C2's wounds by the RN. There was no information in C2's medical record regarding the wound culture results or whether C2's ulcers

were evaluated by a wound clinic.

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AND PLAN OF CORRECTION  (X1) PHOVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED		
		H20449	B. WING			C <b>09/2016</b>
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KSMSO	UR HOUSE LLC		MN 55912			
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01080	Continued From pa	ge 21	01080			
	that C2 was seen in for multiple areas or and inner groin, inclusion on the left innopen ulceration on tom x 2.0 cm open ulbuttock, a 0.3 cm x gluteal fold, and two buttock measuring 0.8 cm. All areas we culture was obtained discharge orders included to change of the company ordered Mepilex dreamd inner groin and were to "assess for C2's facility medical"	record did not include any				
	nursing assessment progress notes pert	ts of C2's skin or any nursing aining to C2's skin status or no information on C2's care				
	that C2 was seen in for an unstageable under admitted for hospitathe heel wound, with MRSA and Strep. Calcanectomy (a surron 08/06/16. C2 was for 13 days. During and groin wounds with specific wound treat	, dated 08/03/16, indicated the emergency department alcer on the left heel. C2 was lization with osteomyelitis of a culture results positive for 2 underwent a left heel rgical limb salvage procedure) a very ill and was hospitalized hospitalization, C2's buttock ere also evaluated with ments initiated. C2 was the facility on 08/17/16 with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING	i	С	
		H20449	B. WING			) 09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC		STREET NO MN 55912	ORTHWEST		
0/4) 15	CHMMADV CT/	ATEMENT OF DEFICIENCIES	T	DDOWNERS DIAM OF CORRECT		***************************************
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01080	Continued From pa	age 22	01080			
		for specific protocols to treat and left heel surgical incision.				
	C2 upon facility rea did not include any nursing progress no C2's medical record	ence that the RN reassessed admission. C2's medical record nursing assessments or otes about C2's skin status. d was void of any Skin and ants pertaining to C2's heel and				
	C2 was re-hospitalized on 09/07/16. C2's facility medical record was void of any nursing progress notes from 08/03/16 to 09/07/16 or any indication as to why C2 had to be hospitalized on 09/07/16.					
	that C2 presented the by ambulance, after unresponsive state were open but C2 with stimuli. C2 had a feroxygen saturations oxygen. Both of C2 lower leg was red ablisters, with an acception of the case of the ca	d, dated 09/07/16, indicated to the emergency department of family called 911 due to C2's. On hospital arrival, C2's eyes was not responding to any ever of 101 degrees with not above 87% on 6 liters of 's feet were blue. C2's left and swollen with fluid filled ewrap that was bound too appearance of "rug-burns," in ous cellulitis. C2's sacral ulcernace previous hospitalization on admitted to the ICU with ions of the left leg, sacrum, and pneumonia. C2's condition on volume resuscitation and tibiotics. Comfort measures 22 was discharged to a skilled 19/16 to receive hospice care.				
	record erroneously	mary in C2's facility medical indicated that C2 was e facility on 09/09/16 to a				

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1	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
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		H20449	B. WING		1	) 9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC		STREET NO VIN 55912	DRTHWEST		
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01080	Continued From pa	ge 23	01080			
		on comfort measures. The				
		y did not include any was transferred to the				
		6 due to a change in condition				
	and never returned					
		discharge summary identified oncerns as diabetes and				
	recent pneumonia.	The discharge summary was				
	void of any informat	tion about C2's wounds.				
		nducted with RCA/D on				
		m., RCA/E on 10/05/16 at 9:16 05/16 at 9:50 a.m., RCA/G on				
	10/05/16 at 7:25 a.r	m., and RCA/H on 10/05/16 at				
		aff stated that C2 had open el and buttocks that				
	progressively worse					
!		taff had informed RN/B about ndition of C2's wounds.				
	the deteriorating col	nullion of G2's wounds.				
		I indicated that C4 receives 5 tinuously due to chronic				
		ary disease. C4 also uses				
	CPAP. C4 is weight	ed daily to monitor symptoms				
	and able to express	failure. C4 is alert, oriented, her needs.				
:	•					
		onducted with C4 during the 28/16. C4 stated she fell while				
	going to the bathroo	om at 10:30 p.m. on 09/05/16.				
		inful and there was blood on Unlicensed staff sent C4 to				
	the emergency roon	n where she was diagnosed			and Advincential	
	with a broken left 5t	h toe and laceration between				
		required stitches. When C4 ity, the nurse never checked				
	the injury or change	d the bandage even though				
		ne nurse check it. Rather, the nge C4's foot bandage. C4				
and the second		ncy department again on	·			

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		H20449	B. WING	774.09.09.00.00	12/0	C <b>09/2016</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I	STREET NO MN 55912	DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01080	09/27/16 due to sho lower leg swelling w 24 hours. C4 return of 09/27/16 with act the nurse the paper nurse has not chec returned from the h.  A Resident Event R p.m. confirmed that injured her left foot, room. RN/B signed 09/06/16 at 8:00 a.r broken left 5th toe wantibiotics, and was provider on 09/15/1 was void of any RN notes pertaining to no information in C4RN assessment of and edema that nec on 09/27/16, nor ware-assessment after hospital.  C3's medical record history of falls and rambulation. C3 also unlicensed staff are An interview was coinvestigation of 09/2 broke her left knee recently started goir On a day to day bas wound and change.	ortness of breath and bilateral with an 11 pound weight gain in led to the facility the same day e wraps on both legs. C4 gave work the hospital sent but the ked C4's legs since C4 ospital.  Report, dated 09/05/16 at 10:30 c C4 fell in the bathroom, and went to the emergency the Resident Event Report on m. and noted that C4 had a with laceration, was started on to follow up with a medical 6. C4's facility medical record assessments or progress C4's left foot injury. There was 4's medical record regarding C4's respiratory symptoms resistated hospital evaluation as there any evidence of RN or C4 returned from the dindicated that C3 has a requires staff assistance with the has a history of cellulitis and to assist C3 with "leg wraps."  Inducted with C3 during the 28/16. C3 stated she fell and cap four weeks ago and has no to a wound clinic weekly. Sis, the RCAs clean the knee the dressing.	01080			
	p.m., confirmed that	t staff found C3 on the floor in a cut on her left knee. The				

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AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER		l ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20449	B. WING	The state of the s	1	9/2016
	PROVIDER OR SUPPLIER	204 14TH	DRESS, CITY, S STREET NO MN 55912	STATE, ZIP CODE DRTHWEST		
040.15	CLIMANA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		T 0.60
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01080	Continued From pa	ge 25	01080			
	07/26/16 at which ti going to Urgent Car C3 was complaining standing on it. Ther C3's medical record problem. C3's medi assessments or pro-					
	at 9:05 a.m., 10:58 stated her role is to care and follow-up of occurred. RN/B ack specific nursing pra resident assessment client changes in coreassessment when provider appointment had no explanation assessment and followed the acute problems.	n clients return from medical nts or hospitalizations. RN/B for the inadequate nursing low up of C2's wounds and experienced by C3 and C4.				
	the role or responsi	bilities of the RN.				
dayun ahdalan dayan	Time Period for Cor	rection: Twenty-one (21) days				
01105 SS=G	144A.4795, Subd. 2 Professionals and N	Licensed Health Jurses	01105			
	nurses. (a) Licensed nurses providing home care a licensed home ca current	nealth professionals and dealth professionals and esservices as an employee of the provider must possess a for registration to practice.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING		1 ,	C	
		H20449	B. WING			09/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC			ORTHWEST		
(X4) ID	SUMMARY STA	AUSTIN, I	MN 55912	PROVIDER'S PLAN OF CORRECT	ION .	(VE)
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01105	Continued From pa	ige 26	01105			
	nurses must be conneeds, planning appropriate client needs, implet supervising staff if assigned.  (c) Nothing in this strights of nurses or late to provide services without or registrations, as This MN Requirements. This MN Requirements with the missing the service oversight of client numbers oversight oversight of client numbers oversight of client numbers oversight of client numbers oversight of client numbers oversight of client numbers oversight of client numbers oversight of client numbers oversight oversight oversight oversight oversight oversight numbers oversight oversight oversight oversight oversight oversight oversight oversight oversight oversight oversight oversight numbers oversight ove	and document review, the ure sufficient registered nurse leeds and client care for 2 of 2 1 and C2). C1 fell and so of leg fracture for ten days assess or monitor. C2 had with heel and buttock wounds				
00000	Findings include:					
	indicated that C1 no confined to a wheel with her feet. C1 ne staff to stand and p unsteadiness when and history of falls. one staff for all activerbally express he alone in her apartm	sment, dated 01/12/16, o longer ambulated. C1 was chair which C1 could propel eded the assistance of one livot for transfers, due to C1's standing, balance problems, C1 needed the assistance of vities of daily living. C1 could r needs and desires. C1 lived ent and wore a pendant that lert staff when she needed				

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AND DIAN DE CORRECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		H20449	B. WING		12/0	9/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	STREET NO	DRTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	)N	(VE)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
01105	Continued From pa	ge 27	01105			
01105	A Resident Event R (Saturday) at 3:45 a staff because she has Resident Care Assifound C1 sitting on wheelchair. C1 told when she fell, but sanother staff assisted After C1 fell on 07/2 that C1 was assess Interviews were cor 10/05/16 at 7:25 a.r a.m., and RCA/H or three staff stated the in condition after the RCA/E stated that C1 compositing in the recline stated that C1 compositing in the recline stated that C1 compositing during transted that C1 compositing during transted that C1 compositing during transted to wear her legs when staff app RCA/H all submitted about C1's painful let transferring, and check An interview was condition after the An interview was conditionally condit	report, dated 07/23/16 a.m., indicated that C1 paged and fallen in her apartment. stant (RCA)/G responded and the floor next to the RCA/G that she hit her knees he was "alright." RCA/G and	01105			
	and difficulty with tra 07/23/16. After the	ansfers after C1 fell on OHFC investigation started, computer and all of the				

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STATEMENT OF DEFICIENCIES (X1)

A. BUILDING:  COMPLET  COMPLET  COMPLET  COMPLET	
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H20449 B. WING 12/09/2	2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
KSMS OUR HOUSE LLC 204 14TH STREET NORTHWEST AUSTIN, MN 55912	
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Ontinued From page 28  Concern Forms completed by the RCAs regarding C1 were absent in the computer. On prior occasions, HM/C has observed RN/B rip up Concern Forms or delete them from the computer.  Interviews were conducted with RN/B on 09/28/16 at 9:05 a.m., 10:58 a.m., and 4:30 p.m. RN/B stated she works full time at the facility Monday through Friday. RN/B is the only nurse employed for this location. RN/B's role is to direct and oversee all client care and follow-up on Concern Forms regarding client problems. RN/B's stated that after C1 fell on 07/28/16, C1 had some bruising and swelling to the right knee but C1 transferred all week without any difficulty standing and pivoting. RN/B denied that RCA staff submitted any Concern Forms pertaining to C1. RN/B made two brief progress notes (07/25/16 and 08/02/16) in the electronic record, which did not include any detailed assessment information.  RN/B's statement about C1's condition directly conflicted with statements from several caregivers who provided C1's bedside care the week after C1 fell.  At the time of the onsite investigation, C1's electronic record was reviewed and did not include any Concern Forms after 07/23/16, C1's nursing progress notes contained two entries by RN/B, one dated 07/25/16 and another dated 08/02/16. The progress note on 07/25/16 indicated that RN/B shorke to C1 on 07/25/16 about C1's 07/23/16 fall. There was no evidence that RN/B thoroughly assessed C1 for any potential injuries or examined C1's knees, even though C1 had told staff that she hit her knees during the fall. There was no evidence of any	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20449	B. WING		1	) 9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N		DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01105	08/02/16, at which to indicated that C1 wheright knee. RN/I knee was "bruised a character, extent, a swelling was not incevidence that RN/B or how it impacted that the character mode for constand and pivot.  C1's nursing progress blank. C1's nursing 07/25/16 were blank. C1's nursing 07/25/16 were blank. C1's hospital record declined during host discharged from the facility on 08/10/16.  C2's nursing assess 06/16/16, indicated impaired and complete and was unable to stransferred by two stappers a pressure-relieving night. C2 was incomby staff every four his kin barrier cream a incontinence. Staff was ordered by C2's stransferred by	time a progress note by RN/B as complaining of soreness in a documented that C1's right and swollen" but the degree, and location of bruising and dicated. There was no assessed C1's degree of pain C1's activities of daily living. Ence that RN/B evaluated C1's continued appropriateness to a ses notes after 08/02/16 were progress notes prior to a sk. C1 resided at the facility for a took C1 to the hospital on the tion of C1's leg pain, where it at C1's right leg was broken. I indicated that C1 further pitalization and was a hospital to a skilled nursing a sment and plan of care, dated that C2 was cognitively letely reliant on care givers for living. C2 could not ambulate stand for transfers. C2 was taff with a hoyer lift. C2 wore a boot on her left foot each tinent and was to be toileted ours. Staff were to apply a after each episode of were to "treat any open area doctor," but neither the tanor the care plan specified	01105			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CONTECTION	IDEIALII IOVI IOIA IAOIAIDEU'	A. BUILDING:			
		H20449	B. WING			) 9 <mark>/2016</mark>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, N	STREET NO MN 55912	DRTHWEST		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01105	C2's only Skin and completed by RN/B 04/03/14, at which on the inside edge 2 cm x 1.5 cm. C2's include any further nursing progress no Stage II pressure u hospital discharge sindicated that C2 has the sacrum and right documented). The indicated that facilit positions frequently to the ulcers.  There was no information from the control of RN assessment of RN assessment of RN assessment of the culture was decubitus ulcer. Faction of C2's wound culture was decubitus ulcer. Faction information in C2 the wound culture rewere evaluated by a C2's hospital record that C2 was seen in C2's was seen in C2's hospital record that C2 was seen in C2's was	Wound Assessment was a over two years ago on time C2 had a Stage II ulcer of the right buttock, measuring a medical record did not wound assessments or otes about status of C2's licer on the right buttock, until a summary dated 03/10/16 and Stage II pressure ulcers on the gluteus (measurements not hospital discharge summary yestaff needed to change C2's and apply Mepilex dressings and apply Mepilex dressings are ulcers, need for Mepliex for frequent position changes sure. There was no evidence for follow-up.  Impleted by unlicensed staff and that C2 had a "big open to the clinic on a provider documented that a cobtained from C2's left buttock cility staff were to apply an sealily for 10 days and follow inc. There was no evidence of C2's wounds or follow-up wounds by the RN. There was 2's medical record regarding esults or whether C2's ulcers	01105			
		uding a 4.5 cm x 0.7 cm open				

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
			A. Bollbind.		,	l c	
	TOWARD COMMENT	H20449	B. WING			09/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
KSMS O	UR HOUSE LLC	204 14TH AUSTIN, I		ORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
01105	lesion on the left in open ulceration on cm x 2.0 cm open ul buttock, a 0.3 cm x gluteal fold, and two buttock measuring 0.8 cm. All areas v culture was obtained discharge orders in C2's perineal care at that was to be provinospital physician oneeded to change and offload pressur ordered Mepilex drand inner groin and were to "assess for C2's facility medicanursing assessment progress notes performed wounds.  C2's hospital record that C2 was seen in for an unstageable admitted for hospitatine heel wound, wit MRSA and Strep. Calcanectomy (a sur on 08/06/16. C2 was for 13 days. During and groin wounds v specific wound treat discharged back to physician's orders for C2's buttock ulcers.  There was no evident treatment of the control of	ner groin, a 3.5 cm x 2.0 cm the right lower buttock, a 4.5 culceration on the right upper 5.0 cm open ulceration on the left 0.5 cm x 0.5 cm and a 0.5 x were macerated. A wound ed. The hospital physician's cluded a specific protocol for and incontinence management ided by facility staff. The documented that facility staff C2's position every two hours re. The hospital physician essings to the buttock ulcers I documented that facility staff	01105				

Minnesota Department of Health

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
		H20449	B. WING		12/0	) 9/ <b>2016</b>
	PROVIDER OR SUPPLIER	204 14TH	DRESS, CITY, S STREET NO MN 55912	STATE, ZIP CODE DRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
01105	did not include any nursing progress not C2's medical record Wound Assessmen buttock wounds. The C2's care plan regated to the care facility on 10/05/16 at 7:25 a.m.	nursing assessments or otes about C2's skin status. It was void of any Skin and ts pertaining to C2's heel and there was no information on right C2's wounds.  Zed on 09/07/16. C2's facility void of any nursing progress to 09/07/16 or any indication to be hospitalized on 09/07/16.  If, dated 09/07/16, indicated the emergency department of family called 911 due to C2's On hospital arrival, C2's eyes was not responding to any over of 101 degrees with not above 87% on 6 liters of the set were blue. C2's left and swollen with fluid-filled the wrap that was bound too appearance of "rug-burns," in the cellulitis. C2's sacral ulcer are previous hospitalization on dimitted to the ICU with ons of the left leg, sacrum, and pneumonia. C2's condition and ibiotics. Comfort measures 2 was discharged to a skilled 19/16 to receive hospice care.  ducted with RCA/D on no., RCA/E on 10/05/16 at 9:50 a.m., RCA/G on no., and RCA/H on 10/05/16 at 19:16 at 19:50 a.m., RCA/G on no., and RCA/H on 10/05/16 at 19:16 at 15 at 1	01105			

(X2) MULTIPLE CONSTRUCTION

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		H20449	B. WING		12/0	) 9/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
1/01/0	UD 110110E 1 1 0	204 14TH	STREET NO	PRTHWEST		
KSMS OUR HOUSE LLC AUSTIN, I			/IN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRESS OF THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
01105	Continued From pa	ge 33	01105			
		staff had informed RN/B about ndition of C2's wounds.				
	at 9:05 a.m., 10:58 stated her role is to care and follow-up occurred. RN/B ack specific nursing praresident assessment client changes in coreassessment when provider appointmenhad no explanation documentation in Cothe ongoing status. The facility did not her the role or responsi	n clients return from medical nts or hospitalizations. RN/B for the inadequate '2's medical record denoting of C2's wounds.				
01155 SS=F	(d) When the regist	7(d) RN/LHP Responsibilities ered nurse or licensed health tes tasks, they must ensure	01155			
	that prior to the delegative trained in the prope tasks or procedures for each demonstrate the ab procedures and perform the task has not regularly percare task for a period of	on the unlicensed personnel is r methods to perform the n client and are able to illity to competently follow the eks. If an unlicensed personnel erformed the delegated home		·		

Minnesota Department of Health

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION i:	1 ` '	(X3) DATE SURVEY COMPLETED	
		H20449	B. WING			C <b>12/09/2016</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE	1	55/2010	
KSMS O	UR HOUSE LLC		SIREEL NO MN 55912	ORTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
01155	appropriate license registered nurse or must document ins tasks in the client's  This MN Requirement by: Based on interview facility failed to ensure properly trained nursing tasks that we registered nurse for of 9 clients reviewe who received deleg the absence of document described and the corresponding of the correspondi	task to the registered nurse or d health professional. The licensed health professional tructions for the delegated record.  ent is not met as evidenced and document review, the ure that unlicensed personneled to perform delegated vere supervised by the raccurate implementation, in 5 d (C1, C2, C3, C4, and C7), ated nursing procedures in umented instructions for the dindicated that unlicensed buttock and heel dressings record also indicated that ministered C2's daily insulin. It indicated that MRSA and during a culture of C2's heel mation on C2's care plan ands. C2's medical record was uctions and evidenced-based of for unlicensed personnel delegated nursing and care and insulin re was no evidence that the censed staff in the proper	01155				

Minnesota Department of Health

1	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION i:		E SURVEY PLETED	
		H20449	B. WING		4	C <b>12/09/2016</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
KSMSO	UR HOUSE LLC			ORTHWEST			
			MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
01155	10/05/16 at 8:32 a. a.m., and RCA/G of three staff stated the left heel and buttood three staff stated the Mepilex dressing of ever receiving any from the RN on how All three staff stated their dressing chan wound care was be RCA/D stated shed dressing by following Mepilex package. For training instructions perform the Mepile observations shess appearance of C2's observed RCA/D pand RCA/D did C2's for over two years, personal observations allooked like. RCA/D without any written RN/B. Five years and RCA/D how to dialladminister C2's insobserved RCA/D's RCA/H stated shepmany times. C2 had and the wound dresurine when RCA/H RCA/H would reapply when the dressing the RCA/H how to apply never provided any	m., RCA/H on 10/05/16 at 7:56 on 10/05/16 at 7:25 a.m. All nat C2 had open sores on her eks that would not heal. All ney routinely performed C2's hanges to the wounds without verbal or written instructions w to do the dressing changes. It dearned how to do the Mepilex neg technique to ensure C2's being implemented properly.  Itelarned how to do the Mepilex neg the instructions on the RN/B never provided any at the instructions on the RN/B never provided any at the instructions on the regarding the seconds. RN/B never erform the Mepilex dressing seconds. RN/B never erform the Mepilex dressing seconds. RN/B never erform the Mepilex dressing seconds of C2's wounds but RN/B lask RCA/D what C2's sores also gave C2's daily insulin, instructions or oversight from go, another nurse showed the insulin pens and ulin but RN/B has never technique for accuracy.  Derformed C2's personal care do a "huge" sore on her tailbone seing was often saturated with performed incontinence care. Day a new Mepilex dressing. RN/B wound care instructions to y observations of RCA/H's	01155				

Minnesota Department of Health

STATE FORM

(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMPI	LETED
		H20449	B. WING		12/0	) 9/2016
	PROVIDER OR SUPPLIER	204 14TH	DRESS, CITY, STREET NO WN 55912	STATE, ZIP CODE DRTHWEST		
(X4) ID PREFIX TAG	) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		D BE	(X5) COMPLETE DATE		
01155	wound care techniq months C2 resided sore looked infected mucus" oozing from RCA/G stated that a how to change C2's observed RCA/G's were no written inst do the dressing chance heel that kept o staff forwarded at le RN/B about C2's he training was ever proceed was void of a evidenced-based counlicensed personn delegated nursing padministration.  C7's medical record staff perform C7's nechanging C7's nephrecord was void of a evidenced-based counlicensed personn delegated nursing padministration.  C7's medical record staff perform C7's nephrecord was void of a evidenced-based counlicensed personn nursing procedure for the provides C7's care.  An interview was counlicensed personn nursing procedure for the provides C7's care.  RN/B that she didn't nephrostomy bag, I	ue. During the last couple at the facility, C2's tailbone d and had "green slimy it.  another RCA showed RCA/G bandages but RN/B never dressing technique and there ructions from RN/B on how to larges. C2 also had a sore on ozing all over the bed. RCA east four Concern Forms to leel but no instructions or lovided to her by RN/B.  I indicated that unlicensed C1's daily insulin. C1's medical written instructions and ompetency training for el who had performed the	01155			
		G how to change C7's				
					I	

(X2) MULTIPLE CONSTRUCTION

Minnesota Department of Health

Minnesota Department of Health

1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
ANDFLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMP	LETED
		H20449	B. WING			C 09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
KSMS O	UR HOUSE LLC		STREET NO VIN 55912	ORTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01155	An interview was convestigation of 09/2 nephrostomy bag frought which is upset the nurse follows up.  C4's medical record staff perform C4's dand CPAP treatmer void of written instructompetency training who perform the de C4's dressing change.  An interview was convestigation of 09/2 going to the bathrood C4's left leg was pathe bathroom floor. The emergency room with a broken left 5the 4th/5th toe that returned to the facilitate injury or change C4 requested that the RCAs routinely characteristics and reambulation. C3 also unlicensed staff are C3's medical record instructions and evid training for unlicensed delegated nursing penanges.  An interview was converted to the facilitation of the facili	onducted with C7 during the 28/16. C7 stated his requently leaks during the ting to him. C7 doesn't think on his concerns.  I indicated that unlicensed dressing change to the left foot his. C4's medical record was actions and evidenced-based of for unlicensed personnel legated nursing procedure for ges and CPAP treatments.  Inducted with C4 during the 28/16. C4 stated she fell while om at 10:30 p.m. on 09/05/16. inful and there was blood on Unlicensed staff sent C4 to m where she was diagnosed h toe and laceration between required stitches. When C4 ity, the nurse never checked in the bandage even though the nurse check it. Rather, the nege C4's foot bandage.  I indicated that C3 has a requires staff assistance with thas a history of cellulitis and to assist C3 with "leg wraps." I was void of written denced-based competency ed personnel who perform the rocedure for C3's dressing	01155			
	investigation of 09/2	8/16. C3 stated she fell and cap four weeks ago and has				

Minnesc	ota Department of He	<u>alth</u>				
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMP	SURVEY
		H20449	B. WING		12/0	) 9/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
KSMS O	OUR HOUSE LLC	204 14TH AUSTIN, M	STREET NO MN 55912	PRTHWEST		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01155	recently started goin On a day to day bas wound and change Interviews were cor at 9:05 a.m., 10:58 stated that it is the RN to train unlicens nursing procedures prior to staff perform the RN validates stachanges, nephrosto administration would nursing tasks. RN/E inadequate nurse or procedures to unlice	ng to a wound clinic weekly. sis, the RCAs clean the knee the dressing.  Inducted with RN/B on 09/28/16 a.m., and 4:30 p.m. RN/B role and responsibility of the sed staff for all delegated s. The training needs to occur ming the delegated task and aff competency. Dressing omy care, and insulin do constitute delegated B had no explanation regarding versight of delegated nursing	01155			
01225 SS=F	Subd. 3. Supervision nursing or therapy have perform delegals care tasks must be licensed health profiperiodically where the provided to verify the performed compete and solutions relate to perform the tasks performing medication administration shall nurse or appropriate and must include observing medicals.	ently and to identify problems of to the staff person's ability s. Supervision of staff ion or treatment be provided by a registered e licensed health professional	01225			

interaction with

Minnesota Department of Health

i .	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	A. Bolebird.		c	
	7.01	H20449	B. WING	B. WING		12/09/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	STATE, ZIP CODE			
KSMS O	UR HOUSE LLC		I STREET NO MN 55912	DRTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
01225	Continued From pa	ige 39	01225				
	the client.						
	delegated tasks mu after the individual begin provider and therea performance. This requirement al not performed deledonger.  This MN Requirement by: Based on interview facility failed to ensidelegated to unliced periodically supervisensure competency clients reviewed (Competency and the individual of the individual	rvision of staff performing ust be provided within 30 days is working for the home care after as needed based on also applies to staff who have gated tasks for one year or ent is not met as evidenced and document review, the ure that nursing tasks insed personnel were sed by the registered nurse to y of unlicensed staff for 5 of 9 1, C2, C3, C4, and C7).					
	staff administered C the facility for four y no Supervisory Visit oversight of insulin staff.  C2's medical record staff performed C2's C2's left heel and be record had no Super to RN oversight of C staff.  C1's medical record staff administered C	d indicated that unlicensed C2's daily insulin. C2 resided in tears. C2's medical record had to Notes pertaining to RN adminsitration by unlicensed dindicated that unlicensed so daily dressing changes for uttock wounds. C2's medical ervisory Visit Notes pertaining C2's wound care by unlicensed dindicated that unlicensed dindicated that unlicensed c1's daily insulin. C1 resided at ears. C1's medical record					

12/09/2016

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION

**IDENTIFICATION NUMBER:** 

H20449

(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
B. WING	C 12/09/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KSMS OUR HOUSE LLC 204 14TH STREET NORTHWEST AUSTIN, MN 55912						
(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		
01225	Continued From page 40	01225				
	contained one Supervisory Visit Note pertaining to RN oversight of C1's insulin administration. A Supervisory Visit Note, dated 12/16/15, indicated that RN/B observed one employee, Resident Care Assistant (RCA)/J, perform C1's insulin administration at which time RN/B reviewed the insulin administration procedure with RCA/J. C1's medical record had no other Supervisory Visit Notes pertaining to RN oversight of delegated nursing tasks.					
	C7's medical record indicated that unlicensed staff perform C7's nephrostomy care, including changing C7's nephrostomy bag. C7's medical record had no Supervisory Visit Notes pertaining to RN oversight of C7's nephrostomy care by unlicensed staff.					
	C4's medical record indicated that unlicensed staff perform C4's dressing change to the left foot and CPAP treatments. C4's medical record had no Supervisory Visit Notes pertaining to RN oversight of C4's dressing changes and CPAP treatments.					
	C3's medical record indicated that unlicensed staff perform C3's left leg dressing changes. C3's medical record had no Supervisory Visit Notes pertaining to RN oversight of C3's dressing changes.					
	Interviews were conducted with RN/B on 09/28/16 at 9:05 a.m., 10:58 a.m., and 4:30 p.m. RN/B stated she has worked full time at the facility, Monday through Friday, for the last four years. RN/B is the only nurse employed by the facility. RN/B's role is to direct and oversee all client care and follow-up on client problems that have occurred. RN/B was aware of the need for routine supervisory oversight of nursing tasks delegated epartment of Health					

PRINTED: 12/12/2016

**FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ C B. WING \_\_ H20449 12/09/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **204 14TH STREET NORTHWEST** KSMS OUR HOUSE LLC

AUSTIN, MN 55912						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	/ FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE		
01225	Continued From page 41 to unlicensed staff. RN/B had no explar the inadequate nurse oversight of unlic who performed delegated nursing proc	ensed staff				
	RN/B acknowledged that she did not hat system to ensure that all staff performing delegated nursing procedures were continuously tasks they performed.	ave a				
	Time Period for Correction: Twenty-one days.	e (21)				

Minnesota Department of Health

STATE FORM



Protecting, Maintaining and Improving the Health of All Minnesotans

August 22, 2017

Mr. Randy Klein, Administrator Ksms Our House LLC 204 14th Street Northwest Austin, MN 55912

RE: Complaint Number HL20449016 and HL20449017

Dear Mr. Klein:

On May 16, 2017 an investigator of the Minnesota Department of Health, Office of Health Facility Complaints completed a re-inspection of your facility, to determine correction of orders found on the complaint investigation completed on December 9, 2016 with orders received by you on December 23, 2016. At this time these correction orders were found corrected and are listed on the attached State Form.

You are encouraged to retain this document for your records. 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. Please feel free to call me with any questions.

Sincerely,

Matthew Herron

Matthew Heffron, JD, NREMT Health Regulations Division Office of Health Facility Complaints 85 East Seventh Place, Suite 220 P.O. Box 64970 St. Paul, MN 55164-0970

Telephone: (651) 201-4221 Fax: (651) 281-9796

MH/ja Enclosure

cc: Home Health Care Assisted Living File Mower County Adult Protection Office of Ombudsman MN Department of Human Services