MDH Minnesota Department of Health

## Office of Health Facility Complaints Investigative Report
**PUBLIC**

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| **Facility Name:** KSMS Our House LLC | | **Report Number:** HL20449017 | **Date of Visit:** September 28, 2016 |
| **Facility Address:** 204 14th Street NW | | **Time of Visit:** 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<br>Kathy Smith, RN, Special Investigator | |
| **State:** Minnesota | **ZIP:** 55912 | **County:** Mower | |

☒ **Home Care Provider/Assisted Living**

### 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) x 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.

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 cm x 0.7 cm open lesion on the left inner groin, a 3.5 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 areas on the left buttock measuring 0.5 cm x 0.5 cm and 0.5 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

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):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ 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):

**Definitions:**

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

"Neglect" means:

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

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

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

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

**Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated**

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of

maltreatment occurred.

**The Investigation included the following:**

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

- [x] Medical Records
- [x] Care Guide
- [x] Medication Administration Records
- [x] Nurses Notes
- [x] Assessments
- [x] Physician Orders
- [x] Treatment Sheets
- [x] Physician Progress Notes
- [x] Care Plan Records
- [x] Skin Assessments
- [x] Facility Incident Reports
- [x] Service Plan

**Other pertinent medical records:**

- [x] Hospital Records

**Additional facility records:**

- [x] Staff Time Sheets, Schedules, etc.
- [x] Facility Internal Investigation Reports
- [x] Personnel Records/Background Check, etc.
- [x] Facility In-service Records
- [x] Facility Policies and Procedures

Number of additional resident(s) reviewed: Eight

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

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

○ Yes ◉ No ○ N/A

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

**Interviews: The following interviews were conducted during the investigation:**

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify: _____

If unable to contact complainant, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

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

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: The client was discharged.

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Seven

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

**Tennessen Warnings**

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Eight

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

**Observations were conducted related to:**

- [x] Personal Care
- [x] Nursing Services
- [x] Use of Equipment
- [x] Cleanliness
- [x] Dignity/Privacy Issues
- [x] Safety Issues
- [x] Facility Tour

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ◉ Yes ○ No ○ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

cc:

**Health Regulation Division - Home Care & Assisted Living Program**

**Minnesota Board of Nursing**

**The Office of Ombudsman for Long-Term Care**

**Austin Police Department**

**Mower County Attorney**

**Austin City Attorney**

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

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| 0 000 | Initial Comments<br><br>****ATTENTION****<br><br>HOME CARE PROVIDER LICENSING ORDER<br><br>In accordance with Minnesota Statutes section 144A.43 to 144A.482, this correction order (s) has been issued pursuant to a survey.<br><br>On 09/28/16, complaint investigations were initiated to investigate Complaints #HL20449016 and #HL20449017. At the time of the survey, there were 79 clients that were receiving services under the comprehensive license. The following correction orders are issued: | 0 000 | | |
| 0 325 SS=G | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights:<br>(14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms<br>of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure that clients were free from neglect when the facility failed to assess or monitor 2 of 9 clients reviewed (C1 and C2) who both had changes in condition requiring hospitalization. C1 fell and broke her leg and was not assessed or monitored by the RN even though C1 exhibited symptoms of fracture for ten days; C1 could not recover during hospitalization and was discharged from the hospital in guarded condition to a skilled care facility to receive hospice care. C2 declined with symptoms of | 0 325 | | |

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| 0 325 | Continued From page 1<br>wound infection that the RN did not assess or monitor; C2 could not recover during hospitalization and was discharged from the hospital to a skilled care facility to receive hospice care.<br><br>Findings include:<br><br>C1's most recent fall risk assessment, dated 12/16/15, indicated that C1 was at high risk for falls.<br><br>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 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 alone in her apartment and wore a pendant that she could push to alert staff when she needed help.<br><br>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. Staff immediately notified House Manager (HM)/C at home that C1 had fallen. The RN on-call was notified of C1's fall at 10:00 a.m. on 07/23/16.<br><br>After C1 fell on 07/23/16, there was no evidence that C1 was assessed by a nurse at any time. There was no evidence that the RN on-call for the | 0 325 | | |

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| 0 325 | Continued From page 2<br>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.<br><br>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.<br><br>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.<br><br>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 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 | 0 325 | | |

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calf was red, swollen, and warm to touch which was suspicious for cellulitis. X-rays confirmed that C1 had a right tibial plateau fracture which was managed conservatively. C1 was hospitalized to treat the cellulitis with intravenous antibiotics. During hospitalization, C1 declined with acute kidney injury and altered mental status. On 08/10/16, C1 was discharged to a skilled care facility in guarded condition with a plan for hospice care.

An interview was conducted with RCA/G on 10/05/16 at 7:25 a.m. RCA/G stated she responded to C1's page at 3:45 a.m. on 07/23/16. RCA/G found C1 sitting on the floor on her buttocks by her recliner, where C1 often sleeps. C1 said she was sore and her right leg hurt. RCA/G and RCA/H transferred C1 back into the recliner by standing C1 up and pivoting her to the recliner. RCA/G then called HM/C at home and notified HM/C that C1 had fallen. RCA/G's shift does not end until 7:00 a.m. and RCA/G routinely gets C1 dressed in the mornings. On the morning of 07/23/16, C1 said her right leg hurt when RCA/G helped C1 to dress. After a couple of days, RCA/G observed purple bruises on C1's right leg, right arm, and right breast. During this time, C1 complained of pain in the right leg when C1 was sitting in the recliner and during transfers. RCA/G performed C1's care several more times that week. RCA/G was never directed by anyone to change C1's transfer mode or make any changes in C1's usual care routine.

An interview was conducted with RCA/H on 10/05/16 at 7:56 a.m. RCA/H stated that C1 had a history of falls. C1 fell during the night of 07/23/16 and was injured. Both of C1's legs were red in color. C1 was normally agreeable to all care but after C1 fell on 07/23/16, C1 was less

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| 0 325 | Continued From page 4<br><br>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 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 fall. All of the Concern Forms and notes that RCA/H entered into the computer had been deleted.<br><br>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 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 | | |

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documented by RN/B pertaining to C1's fall or status. RN/B did enter some progress notes on 08/22/16, after the State agency called the facility and requested records pertaining to C1's 07/23/16 fall. At that time, HM/C checked the computer for the electronic Concern Forms that had been completed by the RCA staff. The Concern Forms were absent in the computer and their contents had not been printed or saved which concerned HM/C. On other occasions, HM/C has observed RN/B rip up Concern Forms or delete them from the computer.

An interview was conducted with RCA/E on 10/05/16 at 9:16 a.m. RCA/E stated she provided C1's care during the week after C1 fell on 07/23/16. Normally C1 could propel her wheelchair with her feet and go independently to the dining room for meals but after C1's fall, C1's legs hurt and C1 could not propel the wheelchair with her feet. C1 asked staff to push her to the dining room for meals. RCA/E observed that C1's entire right side had dark purple bruises that extended from C1's right leg up to C1's right breast. Day by day, the bruising changed color from purple to red and then started swelling. C1 was still standing and pivoting for transfers to the toilet. RCA/E assisted C1 to the toilet numerous times that week and C1 said her leg was sore when she stood on it. RCA/E submitted a Concern Form to RN/B about C1's sore leg. RCA/E did not know if RN/B checked C1's leg. RN/B never advised RCA/E to change C1's transfer mode.

Family member (FM)/I was interviewed on 10/06/16 at 2:20 p.m. FM/I stated she visited C1 on 07/31/16. C1 was in a wheelchair, rubbing her right knee. C1 said her right leg was painful and she couldn't propel her wheelchair with her feet

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| 0 325 | Continued From page 6<br><br>any more because it hurt her leg so the staff were pushing her wheelchair to the dining room for her. C1 wouldn't allow FM/I to look at her leg but C1 said the leg was bruised. FM/I contacted another family member about C1's statements, who visited C1 a couple days later and took C1 to the hospital to have her leg evaluated. Family then learned that C1's right leg was broken. C1 had endured a broken leg for ten days with no intervention.<br><br>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. The agency employs two other nurses who are on-call during hours that RN/B is not onsite at 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 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. When C1 began complaining of pain in the right leg, C1's family member took C1 to the emergency room on 08/03/16. RN/B denied that she received multiple Concern Forms from unlicensed staff regarding C1's symptoms of pain, bruising, and mobility difficulties. RN/B did not know how many times she observed, assessed, or monitored C1's status from 07/23/16 - 08/04/16 or if C1's symptoms progressively worsened during that period of time. RN/B made only two brief progress notes (07/25/16 and 08/02/16) which did not include any detailed assessment information.<br><br>The facility's policy on Resident Falls or Injuries (undated) directed unlicensed staff to assess the client and perform range of motion: "Assess the | 0 325 | | |

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| 0 325 | Continued From page 7<br><br>resident and provide First Aid. Take vital signs and perform range of motion to determine if there is an injury. Be careful not to further injure the resident. Contact Director or person on-call to report the situation. If it is determined that that it is safe to move the resident, assess whether you will be able to do so without injury to yourself or the resident...Complete the Event Report." The facility's policy did not include information pertaining to the responsibilities of the licensed nurse to assess clients after falls and conduct follow up surveillance of the client's status post-fall.<br><br>The facility did not have any policies pertaining to the role or responsibilities of the RN. The facility's policy on Resident Falls inappropriately assigned responsibilty for assessment of client injury to unlicensed staff.<br><br>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 hoyer lift. C2 wore a pressure-relieving boot on her left foot each night. C2 was incontinent and was to be toileted 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 as ordered by C2's doctor," but neither the nursing assessment nor the care plan specified whether C2 had any open areas.<br><br>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 | 0 325 | | |

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| 0 325 | Continued From page 8<br>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.<br><br>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.<br><br>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.<br><br>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 | 0 325 | | |

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| 0 325 | Continued From page 9<br><br>buttock measuring 0.5 cm x 0.5 cm and a 0.5 x 0.8 cm. All areas were macerated. A wound culture was obtained. The hospital physician's discharge orders included a specific protocol for C2's perineal care and incontinence management that was to be provided by facility staff. The hospital physician documented that facility staff needed to change C2's position every two hours and offload pressure. The hospital physician ordered Mepilex dressings to the buttock ulcers and inner groin and documented that facility staff were to "assess for healing each day."<br><br>C2's facility medical record did not include any nursing assessments of C2's skin or any nursing progress notes pertaining to C2's skin status or wounds. There was no information on C2's care plan regarding C2's wounds.<br><br>C2's hospital record, dated 08/03/16, indicated that C2 was seen in the emergency department for an unstageable ulcer on the left heel. C2 was admitted for hospitalization with osteomyelitis of the heel wound, with culture results positive for MRSA and Strep. C2 underwent a left heel calcanectomy (a surgical limb salvage procedure) on 08/06/16. C2 was very ill and was hospitalized for 13 days. During hospitalization, C2's buttock and groin wounds were also evaluated with specific wound treatments initiated. C2 was discharged back to the facility on 08/17/16 with physician's orders for specific protocols to treat C2's buttock ulcers and left heel surgical incision.<br><br>There was no evidence that the RN reassessed C2 upon facility readmission. C2's medical record did not include any nursing assessments or nursing progress notes about C2's skin status. C2's medical record was void of any Skin and Wound Assessments pertaining to C2's heel and | 0 325 | | |

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| 0 325 | Continued From page 10<br>buttock wounds.<br><br>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.<br><br>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 eyes 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 on 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 care facility on 09/09/16 to receive hospice care.<br><br>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 get 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 | 0 325 | | |

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| 0 325 | Continued From page 11<br><br>wrapped C2's heel with gauze. RCA staff would then apply C2's "safety booties." RCA/D learned how to do the Mepilex dressing by following the instructions on the Mepilex package. RN/B never provided any training instructions to RCA/D about how to perform the Mepilex dressing or any pertinent observations staff should make regarding the appearance of C2's wounds. RN/B never observed RCA/D perform the Mepilex dressing and RCA/D did C2's Mepilex dressing changes for over two years. RCA/D never saw RN/B make personal observations of C2's wounds but RN/B would sometimes ask RCA/D what C2's sores looked like.<br><br>An interview was conducted with RCA/H on 10/05/16 at 7:56 a.m. RCA/H stated she performed C2's personal care many times. C2 had a "huge" sore on her tailbone and the wound dressing was often saturated with urine when RCA/H performed incontinence care. RCA/H would reapply a new Mepilex dressing when the dressing was wet. RCA/D showed RCA/H how to apply the Mepilex dressing. RN/B never provided any wound care instructions to RCA/H or made any observations of RCA/H's wound care technique. During the last couple months C2 resided at the facility, C2's tailbone sore looked infected and had "green slimy mucus" oozing from it. Eventually C2 went to the hospital and never came back.<br><br>An interview was conducted with RCA/G on 10/05/16 at 7:25 a.m. RCA/G stated she performed C2's personal care many times. C2 had a sore on her tailbone that was covered with a big bandage. The bandage often fell off because it was saturated with urine so RCA/G would put on a new bandage when incontinence care was done. Another RCA showed RCA/G | 0 325 | | |

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| 0 325 | Continued From page 12<br><br>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.<br><br>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.<br><br>An interview was conducted with RCA/F on 10/05/16 at 9:50 a.m. RCA/F stated that C2 had sores on her tailbone and on her heel. The RCA staff put Mepilex dressing on both wounds. The | 0 325 | | |

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| 0 325 | Continued From page 13<br>sores would start to heal then recur. RN/B would only observe C2's wounds when the RCA staff requested it. At one point toward the end of C2's facility stay, C2 had an ace wrap on the leg over the heel sore. Only RN/B applied the ace wrap. RCA staff were told not to do the ace wrap.<br><br>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 that it is the role and responsibility of the RN to train unlicensed staff for all delegated nursing procedures. The training needs to occur prior to staff performing the delegated task and the RN validates staff competency. A dressing change would constitute a delegated nursing task. RN/B had no explanation regarding inadequate nurse oversight of C2's wound management, including delegated nursing tasks for dressing changes on two wounds. RN/B acknowledged that she was the only employee who applied C2's ace bandage after RCAs completed C2's wound care. RN/B did not know why she did not conduct CMS (circulation, movement, and sensation) checks in connection with C2's ace bandage. RN/B acknowledged that there was no specific nursing practice or facility protocol for resident assessment, follow-up monitoring of client changes in condition, or client reassessment when clients return from medical provider appointments or hospitalizations.<br><br>The facility's policy on Wound Management and Documentation, revised 08/27/13, indicated "Upon admission, upon discharge from the hospital, and upon observation for skin integrity, the team member will check the resident from head to toe, noting any skin areas that are bruised, dry, red, scaly, tender, open, warm to touch or rash-like in appearance. Upon knowledge or discovery, the following information | 0 325 | | |

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| 0 325 | Continued From page 14<br>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."<br><br>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."<br><br>Time Period for Correction: Twenty-one (21) days | 0 325 | | |

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| 01080 | Continued From page 15 | 01080 | | |
| 01080 SS=E | 144A.4794, Subd. 3 Contents of Client Record<br><br>Subd. 3. Contents of client record. Contents of a client record include the following for each client:<br><br>(1) identifying information, including the client's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified;<br>(3) names, addresses, and telephone numbers of the client's health and medical service providers and<br>other home care providers, if known;<br>(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;<br>(5) client's advance directives, if any;<br>(6) the home care provider's current and previous assessments and service plans;<br>(7) all records of communications pertinent to the client's home care services;<br>(8) documentation of significant changes in the client's status and actions taken in response to the<br>needs of the client including reporting to the appropriate supervisor or health care professional;<br>(9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional;<br>(10) documentation that services have been provided as identified in the service plan;<br>(11) documentation that the client has received and reviewed the home care bill of rights; | 01080 | | |

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| 01080 | Continued From page 16<br>(12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3;<br>(13) documentation of complaints received and resolution;<br>(14) discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the client's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>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).<br><br>Findings include:<br><br>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 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 | 01080 | | |

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| 01080 | Continued From page 17<br>alone in her apartment and wore a pendant that she could push to alert staff when she needed help.<br><br>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.<br><br>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."<br><br>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.<br><br>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 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 | 01080 | | |

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| 01080 | Continued From page 18<br><br>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.<br><br>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.<br><br>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.<br><br>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 declined during hospitalization and was discharged from the hospital to a skilled nursing facility on 08/10/16 in guarded condition with a plan for hospice care. | 01080 | | |

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| 01080 | Continued From page 19<br><br>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.<br><br>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.<br><br>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.<br><br>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 hoyer lift. C2 wore a pressure-relieving boot on her left foot each night. C2 was incontinent and was to be toileted 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 | 01080 | | |

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| 01080 | Continued From page 20<br>as ordered by C2's doctor," but neither the nursing assessment nor the care plan specified whether C2 had any open areas.<br><br>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.<br><br>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.<br><br>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. | 01080 | | |

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| 01080 | Continued From page 21<br><br>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 buttock measuring 0.5 cm x 0.5 cm and a 0.5 x 0.8 cm. All areas were macerated. A wound culture was obtained. The hospital physician's discharge orders included a specific protocol for C2's perineal care and incontinence management that was to be provided by facility staff. The hospital physician documented that facility staff needed to change C2's position every two hours and offload pressure. The hospital physician ordered Mepilex dressings to the buttock ulcers and inner groin and documented that facility staff were to "assess for healing each day."<br><br>C2's facility medical record did not include any nursing assessments of C2's skin or any nursing progress notes pertaining to C2's skin status or wounds. There was no information on C2's care plan regarding C2's wounds.<br><br>C2's hospital record, dated 08/03/16, indicated that C2 was seen in the emergency department for an unstageable ulcer on the left heel. C2 was admitted for hospitalization with osteomyelitis of the heel wound, with culture results positive for MRSA and Strep. C2 underwent a left heel calcanectomy (a surgical limb salvage procedure) on 08/06/16. C2 was very ill and was hospitalized for 13 days. During hospitalization, C2's buttock and groin wounds were also evaluated with specific wound treatments initiated. C2 was discharged back to the facility on 08/17/16 with | 01080 | | |

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| 01080 | Continued From page 22<br>physician's orders for specific protocols to treat C2's buttock ulcers and left heel surgical incision.<br><br>There was no evidence that the RN reassessed C2 upon facility readmission. C2's medical record did not include any nursing assessments or nursing progress notes about C2's skin status. C2's medical record was void of any Skin and Wound Assessments pertaining to C2's heel and buttock wounds.<br><br>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.<br><br>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 eyes 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 on 08/03/16. C2 was admitted to the ICU with polymicrobial infections of the left leg, sacrum, and 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 care facility on 09/09/16 to receive hospice care.<br><br>The discharge summary in C2's facility medical record erroneously indicated that C2 was discharged from the facility on 09/09/16 to a | 01080 | | |

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| 01080 | Continued From page 23<br>skilled care facility on comfort measures. The discharge summary did not include any information that C2 was transferred to the hospital on 09/07/16 due to a change in condition and never returned to the facility after hospitalization. The discharge summary identified C2's only medical concerns as diabetes and recent pneumonia. The discharge summary was void of any information about C2's wounds.<br><br>Interviews were conducted with RCA/D on 10/05/16 at 8:32 a.m., RCA/E on 10/05/16 at 9:16 a.m., RCA/F on 10/05/16 at 9:50 a.m., RCA/G on 10/05/16 at 7:25 a.m., and RCA/H on 10/05/16 at 7:56 a.m. All five staff stated that C2 had open sores on her left heel and buttocks that progressively worsened. On numerous occasions, all five staff had informed RN/B about the deteriorating condition of C2's wounds.<br><br>C4's medical record indicated that C4 receives 5 liters of oxygen continuously due to chronic obstructive pulmonary disease. C4 also uses CPAP. C4 is weighed daily to monitor symptoms of congestive heart failure. C4 is alert, oriented, and able to express her needs.<br><br>An interview was conducted with C4 during the investigation of 09/28/16. C4 stated she fell while going to the bathroom at 10:30 p.m. on 09/05/16. C4's left leg was painful and there was blood on the bathroom floor. Unlicensed staff sent C4 to the emergency room where she was diagnosed with a broken left 5th toe and laceration between the 4th/5th toe that required stitches. When C4 returned to the facility, the nurse never checked the injury or changed the bandage even though C4 requested that the nurse check it. Rather, the RCAs routinely change C4's foot bandage. C4 went to the emergency department again on | 01080 | | |

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| 01080 | Continued From page 24<br><br>09/27/16 due to shortness of breath and bilateral lower leg swelling with an 11 pound weight gain in 24 hours. C4 returned to the facility the same day of 09/27/16 with ace wraps on both legs. C4 gave the nurse the paper work the hospital sent but the nurse has not checked C4's legs since C4 returned from the hospital.<br><br>A Resident Event Report, dated 09/05/16 at 10:30 p.m. confirmed that C4 fell in the bathroom, injured her left foot, and went to the emergency room. RN/B signed the Resident Event Report on 09/06/16 at 8:00 a.m. and noted that C4 had a broken left 5th toe with laceration, was started on antibiotics, and was to follow up with a medical provider on 09/15/16. C4's facility medical record was void of any RN assessments or progress notes pertaining to C4's left foot injury. There was no information in C4's medical record regarding RN assessment of C4's respiratory symptoms and edema that necessitated hospital evaluation on 09/27/16, nor was there any evidence of RN re-assessment after C4 returned from the hospital.<br><br>C3's medical record indicated that C3 has a history of falls and requires staff assistance with ambulation. C3 also has a history of cellulitis and unlicensed staff are to assist C3 with "leg wraps."<br><br>An interview was conducted with C3 during the investigation of 09/28/16. C3 stated she fell and broke her left knee cap four weeks ago and has recently started going to a wound clinic weekly. On a day to day basis, the RCAs clean the knee wound and change the dressing.<br><br>A Resident Event Report, dated 07/25/16 at 7:25 p.m., confirmed that staff found C3 on the floor in her apartment with a cut on her left knee. The | 01080 | | |

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| 01080 | Continued From page 25<br><br>Resident Event Report was signed by RN/B on 07/26/16 at which time RN/B noted that C3 was going to Urgent Care for left knee evaluation as C3 was complaining of left knee pain when standing on it. There was no further information in C3's medical record regarding C3's left knee problem. C3's medical record was void of any RN assessments or progress notes.<br><br>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 her role is to direct and oversee all client care and follow-up on client problems that have occurred. RN/B acknowledged that there was no specific nursing practice or facility protocol for resident assessment, follow-up monitoring of client changes in condition, or client reassessment when clients return from medical provider appointments or hospitalizations. RN/B had no explanation for the inadequate nursing assessment and follow up of C2's wounds and the acute problems experienced by C3 and C4.<br><br>The facility did not have any policies pertaining to the role or responsibilities of the RN.<br><br>Time Period for Correction: Twenty-one (21) days | 01080 | | |
| 01105 SS=G | 144A.4795, Subd. 2 Licensed Health Professionals and Nurses<br><br>Subd. 2. Licensed health professionals and nurses. (a) Licensed health professionals and nurses<br>providing home care services as an employee of a licensed home care provider must possess a current<br>Minnesota license or registration to practice. | 01105 | | |

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| 01105 | Continued From page 26<br>(b) Licensed health professionals and registered nurses must be competent in assessing client needs,<br>planning appropriate home care services to meet client needs, implementing services, and supervising<br>staff if assigned.<br><br>(c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to<br>provide services within the scope of their licenses or registrations, as provided by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure sufficient registered nurse oversight of client needs and client care for 2 of 2 clients reviewed (C1 and C2). C1 fell and exhibited symptoms of leg fracture for ten days that the RN did not assess or monitor. C2 had ongoing problems with heel and buttock wounds that the RN did not assess or monitor.<br><br>Findings include:<br><br>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 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 alone in her apartment and wore a pendant that she could push to alert staff when she needed help. | 01105 | | |

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| 01105 | Continued From page 27<br><br>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.<br><br>After C1 fell on 07/23/16, there was no evidence that C1 was assessed by a nurse at any time.<br><br>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 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 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.<br><br>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 OHFC investigation started, HM/C checked the computer and all of the | 01105 | | |

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| 01105 | Continued From page 28<br><br>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.<br><br>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 (07/25/16 and 08/02/16) in the electronic record, which did not include any detailed assessment information.<br><br>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.<br><br>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 spoke 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 further nursing follow-up of C1's status until | 01105 | | |

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| 01105 | Continued From page 29<br><br>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.<br><br>C1's nursing progress notes after 08/02/16 were blank. C1's nursing progress notes prior to 07/25/16 were blank. C1 resided at the facility for ten years.<br><br>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 declined during hospitalization and was discharged from the hospital to a skilled nursing facility on 08/10/16.<br><br>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 hoyer lift. C2 wore a pressure-relieving boot on her left foot each night. C2 was incontinent and was to be toileted 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 as ordered by C2's doctor," but neither the nursing assessment nor the care plan specified whether C2 had any open areas. | 01105 | | |

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| 01105 | Continued From page 30<br><br>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.<br><br>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.<br><br>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.<br><br>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 | 01105 | | |

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| 01105 | Continued From page 31<br><br>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 buttock measuring 0.5 cm x 0.5 cm and a 0.5 x 0.8 cm. All areas were macerated. A wound culture was obtained. The hospital physician's discharge orders included a specific protocol for C2's perineal care and incontinence management that was to be provided by facility staff. The hospital physician documented that facility staff needed to change C2's position every two hours and offload pressure. The hospital physician ordered Mepilex dressings to the buttock ulcers and inner groin and documented that facility staff were to "assess for healing each day."<br><br>C2's facility medical record did not include any nursing assessments of C2's skin or any nursing progress notes pertaining to C2's skin status or wounds.<br><br>C2's hospital record, dated 08/03/16, indicated that C2 was seen in the emergency department for an unstageable ulcer on the left heel. C2 was admitted for hospitalization with osteomyelitis of the heel wound, with culture results positive for MRSA and Strep. C2 underwent a left heel calcanectomy (a surgical limb salvage procedure) on 08/06/16. C2 was very ill and was hospitalized for 13 days. During hospitalization, C2's buttock and groin wounds were also evaluated with specific wound treatments initiated. C2 was discharged back to the facility on 08/17/16 with physician's orders for specific protocols to treat C2's buttock ulcers and left heel surgical incision.<br><br>There was no evidence that the RN reassessed C2 upon facility readmission. C2's medical record | 01105 | | |

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| 01105 | Continued From page 32<br><br>did not include any nursing assessments or nursing progress notes about C2's skin status. C2's medical record was void of any Skin and Wound Assessments pertaining to C2's heel and buttock wounds. There was no information on C2's care plan regarding C2's wounds.<br><br>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.<br><br>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 eyes 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 on 08/03/16. C2 was admitted to the ICU with polymicrobial infections of the left leg, sacrum, and 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 care facility on 09/09/16 to receive hospice care.<br><br>Interviews were conducted with RCA/D on 10/05/16 at 8:32 a.m., RCA/E on 10/05/16 at 9:16 a.m., RCA/F on 10/05/16 at 9:50 a.m., RCA/G on 10/05/16 at 7:25 a.m., and RCA/H on 10/05/16 at 7:56 a.m. All five staff stated that C2 had open sores on her left heel and buttocks that progressively worsened. On numerous | 01105 | | |

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| 01105 | Continued From page 33<br>occasions, all five staff had informed RN/B about the deteriorating condition of C2's wounds.<br><br>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 her role is to direct and oversee all client care and follow-up on client problems that have occurred. RN/B acknowledged that there was no specific nursing practice or facility protocol for resident assessment, follow-up monitoring of client changes in condition, or client reassessment when clients return from medical provider appointments or hospitalizations. RN/B had no explanation for the inadequate documentation in C2's medical record denoting the ongoing status of C2's wounds.<br><br>The facility did not have any policies pertaining to the role or responsibilities of the RN.<br><br>Time Period for Correction: Twenty-one (21) days. | 01105 | | |
| 01155 SS=F | 144A.4795, Subd. 7(d) RN/LHP Responsibilities<br><br>(d) When the registered nurse or licensed health professional delegates tasks, they must ensure that<br>prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or<br>procedures for each client and are able to demonstrate the ability to competently follow the procedures<br>and perform the tasks. If an unlicensed personnel has not regularly performed the delegated home care<br>task for a period of 24 consecutive months, the unlicensed personnel must demonstrate | 01155 | | |

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| 01155 | Continued From page 34<br>competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the client's record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure that unlicensed personnel were properly trained to perform delegated nursing tasks that were supervised by the registered nurse for accurate implementation, in 5 of 9 clients reviewed (C1, C2, C3, C4, and C7), who received delegated nursing procedures in the absence of documented instructions for the tasks.<br><br>Findings include:<br><br>C2's medical record indicated that unlicensed staff changed C2's buttock and heel dressings daily. C2's medical record also indicated that unlicensed staff administered C2's daily insulin.<br><br>C2's hospital record indicated that MRSA and Strep were isolated during a culture of C2's heel on 08/03/16.<br><br>There was no information on C2's care plan regarding C2's wounds. C2's medical record was void of written instructions and evidenced-based competency training for unlicensed personnel who had performed delegated nursing procedures for wound care and insulin administration. There was no evidence that the RN had trained unlicensed staff in the proper handling of infectious waste.<br><br>Interviews were conducted with RCA/D on | 01155 | | |

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| 01155 | Continued From page 35<br><br>10/05/16 at 8:32 a.m., RCA/H on 10/05/16 at 7:56 a.m., and RCA/G on 10/05/16 at 7:25 a.m. All three staff stated that C2 had open sores on her left heel and buttocks that would not heal. All three staff stated they routinely performed C2's Mepilex dressing changes to the wounds without ever receiving any verbal or written instructions from the RN on how to do the dressing changes. All three staff stated the RN had never observed their dressing change technique to ensure C2's wound care was being implemented properly.<br><br>RCA/D stated she learned how to do the Mepilex dressing by following the instructions on the Mepilex package. RN/B never provided any training instructions to RCA/D about how to perform the Mepilex dressing or what pertinent observations she should make regarding the appearance of C2's wounds. RN/B never observed RCA/D perform the Mepilex dressing and RCA/D did C2's Mepilex dressing changes for over two years. RCA/D never saw RN/B make personal observations of C2's wounds but RN/B would sometimes ask RCA/D what C2's sores looked like. RCA/D also gave C2's daily insulin, without any written instructions or oversight from RN/B. Five years ago, another nurse showed RCA/D how to dial the insulin pens and administer C2's insulin but RN/B has never observed RCA/D's technique for accuracy.<br><br>RCA/H stated she performed C2's personal care many times. C2 had a "huge" sore on her tailbone and the wound dressing was often saturated with urine when RCA/H performed incontinence care. RCA/H would reapply a new Mepilex dressing when the dressing was wet. RCA/D showed RCA/H how to apply the Mepilex dressing. RN/B never provided any wound care instructions to RCA/H or made any observations of RCA/H's | 01155 | | |

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| 01155 | Continued From page 36<br>wound care technique. During the last couple months C2 resided at the facility, C2's tailbone sore looked infected and had "green slimy mucus" oozing from it.<br><br>RCA/G stated that another RCA showed RCA/G how to change C2's bandages 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 changes. 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 her by RN/B.<br><br>C1's medical record indicated that unlicensed staff adminsitered C1's daily insulin. C1's medical record was void of written instructions and evidenced-based competency training for unlicensed personnel who had performed the delegated nursing procedure for insulin administration.<br><br>C7's medical record indicated that unlicensed staff perform C7's nephrostomy care, including changing C7's nephrostomy bag. C7's medical record was void of written instructions and evidenced-based competency training for unlicensed personnel who perform the delegated nursing procedure for nephrostomy care.<br><br>An interview was conducted with RCA/G on 10/05/16 at 7:25 a.m. RCA/G stated she routinely provides C7's care. Although RCA/G informed RN/B that she didn't know how to change C7's nephrostomy bag, RN/B never provided any training for RCA/G on nephrostomy care. Another RCA showed RCA/G how to change C7's nephrostomy bag. | 01155 | | |

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| 01155 | Continued From page 37<br><br>An interview was conducted with C7 during the investigation of 09/28/16. C7 stated his nephrostomy bag frequently leaks during the night which is upsetting to him. C7 doesn't think the nurse follows up on his concerns.<br><br>C4's medical record indicated that unlicensed staff perform C4's dressing change to the left foot and CPAP treatments. C4's medical record was void of written instructions and evidenced-based competency training for unlicensed personnel who perform the delegated nursing procedure for C4's dressing changes and CPAP treatments.<br><br>An interview was conducted with C4 during the investigation of 09/28/16. C4 stated she fell while going to the bathroom at 10:30 p.m. on 09/05/16. C4's left leg was painful and there was blood on the bathroom floor. Unlicensed staff sent C4 to the emergency room where she was diagnosed with a broken left 5th toe and laceration between the 4th/5th toe that required stitches. When C4 returned to the facility, the nurse never checked the injury or changed the bandage even though C4 requested that the nurse check it. Rather, the RCAs routinely change C4's foot bandage.<br><br>C3's medical record indicated that C3 has a history of falls and requires staff assistance with ambulation. C3 also has a history of cellulitis and unlicensed staff are to assist C3 with "leg wraps." C3's medical record was void of written instructions and evidenced-based competency training for unlicensed personnel who perform the delegated nursing procedure for C3's dressing changes.<br><br>An interview was conducted with C3 during the investigation of 09/28/16. C3 stated she fell and broke her left knee cap four weeks ago and has | 01155 | | |

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| 01155 | Continued From page 38<br>recently started going to a wound clinic weekly. On a day to day basis, the RCAs clean the knee wound and change the dressing.<br><br>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 that it is the role and responsibility of the RN to train unlicensed staff for all delegated nursing procedures. The training needs to occur prior to staff performing the delegated task and the RN validates staff competency. Dressing changes, nephrostomy care, and insulin administration would constitute delegated nursing tasks. RN/B had no explanation regarding inadequate nurse oversight of delegated nursing procedures to unlicensed staff.<br><br>Time Period for Correction: Twenty-one (21) days. | 01155 | | |
| 01225 SS=F | 144A.4797, Subd. 3 Supervision of Staff - Comp<br><br>Subd. 3. Supervision of staff providing delegated nursing or therapy home care tasks. (a) Staff who perform delegated nursing or therapy home care tasks must be supervised by an appropriate licensed health professional or a registered nurse periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and<br>must include observation of the staff administering the medication or treatment and the interaction with | 01225 | | |

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| 01225 | Continued From page 39<br>the client.<br><br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 days after<br>the individual begins working for the home care provider and thereafter as needed based on performance.<br>This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure that nursing tasks delegated to unlicensed personnel were periodically supervised by the registered nurse to ensure competency of unlicensed staff for 5 of 9 clients reviewed (C1, C2, C3, C4, and C7).<br><br>Findings include:<br><br>C2's medical record indicated that unlicensed staff administered C2's daily insulin. C2 resided in the facility for four years. C2's medical record had no Supervisory Visit Notes pertaining to RN oversight of insulin adminsitration by unlicensed staff.<br><br>C2's medical record indicated that unlicensed staff performed C2's daily dressing changes for C2's left heel and buttock wounds. C2's medical record had no Supervisory Visit Notes pertaining to RN oversight of C2's wound care by unlicensed staff.<br><br>C1's medical record indicated that unlicensed staff administered C1's daily insulin. C1 resided at the facility for ten years. C1's medical record | 01225 | | |

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| | H20449 | A. BUILDING: _____ 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<br>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 adminsitration procedure with RCA/J. C1's medical record had no other Supervisory Visit Notes pertaining to RN oversight of delegated nursing tasks.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | 01225 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H20449 | A. BUILDING: _____ B. WING _____ | C 12/09/2016 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01225 | Continued From page 41<br>to unlicensed staff. RN/B had no explanation for the inadequate nurse oversight of unlicensed staff who performed delegated nursing procedures. RN/B acknowledged that she did not have a system to ensure that all staff performing delegated nursing procedures were competent in the nursing tasks they performed.<br><br>Time Period for Correction: Twenty-one (21) days. | 01225 | | |

DEPARTMENT OF HEALTH

*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 Heffron

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