Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL210519225M
Compliance #: HL210516905C

Date Concluded: April 2, 2024

Name, Address, and County of Licensee Investigated:
Home Front First Assisted Living
224 North 19th Street
Montevideo, MN 56265
Chippewa County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the facility did not assess and implement interventions for a wound and the resident was hospitalized for sepsis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Staff failed to assess, monitor, and provide necessary care to promote healing and prevent worsening of the resident's wound. The resident was sent to the emergency room, airlifted to a higher level of care hospital, and admitted to the intensive care unit (ICU) due to the severity of the wound and septic infection.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the certified nurse practitioner. The investigation included review of the resident's record, hospital records, personnel files, staff

schedules, and facility policies and procedures. At the time of the onsite visit, the investigator observed resident care.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, obesity, and hidradenitis suppurativa (skin condition causing abscesses and scarring). The resident's service plan included assistance with walking, transfers, bed mobility, dressing, toileting, and medication administration.

The resident's medical record identified that upon admission to the facility, the resident had no wounds present and no evidence of skin concerns. Approximately three months after admission, unlicensed personnel (ULP) began documenting evidence of skin breakdown on the resident's coccyx area. ULPs documented they were applying barrier cream to the affected area; however, there was no evidence ULP notified the nurse of these concerns.

Three weeks after the ULP's initial documentation of coccyx area skin concerns, the nurse completed a skin assessment which identified a concern to the resident's coccyx area. The assessment included a blank body diagram image with a red circle over the coccyx area. The assessment did not include additional details, description, or measurement of the area of concern, lacked interventions to prevent further skin breakdown, lacked indication of notification to the resident's primary care provider (PCP), and included no direction on treatment needed to the area. The resident's medical record lacked evidence of follow-up nursing documentation, ongoing assessment, or monitoring of the area, following the nurse's assessment.

Six weeks later, the nurse documented that the resident had a new wound on the coccyx area that she observed that morning and a wound care nurse was contacted. The nurse did not document additional details, description, or measurement of the wound and the note did not reference her previous assessment of the area. Notes from the wound care NP's visit that day described the area as stage 2 pressure ulcer (a scrape, blister, or shallow crater in the skin) that measured 0.2 centimeters (cm) x 1.7 cm x 1 cm, with some necrotic tissue (black, dead tissue), surrounding redness, and moderate serosanguinous (light pink) drainage with no odor. The wound care NP prescribed an oral antibiotic and wrote orders for treatment to the coccyx area. The NP orders indicated she would follow up in two weeks or sooner if problems presented.

The wound care NP's treatment orders were not added to the resident's treatment administration record (TAR) to direct staff on how to apply the dressing, where to the apply the dressing, when to change the dressing, what changes to monitor for, or when the nurse should be notified of changes. The resident's medical record included no evidence of follow-up nursing documentation, ongoing assessment or monitoring of the area, and no notification to the PCP about the wound.

That night ULP documented the coccyx wound was oozing and painful, and another bandage had to be applied to soak up the oozing liquid and puss squirting from the wound. The resident reported feeling dizzy and vital signs were taken; the resident's blood pressure was low, pulse was high, and her temperature was 99.8. The next morning, the resident continued with complaints of dizziness and her vital signs remained unchanged. There was no documentation that a nurse was contacted regarding these concerns. Another ULP documented the resident was having more trouble getting up and could not stand, so they had to use a mechanical lift to assist with transfers and that the wound was looking worse. There was no documentation that a nurse was contacted regarding these concerns.

The resident's medical record included no documentation of the resident's condition or wounds over the next two days and there was no further assessment of the wound or follow-up completed regarding the abnormal vital signs. The medical record also lacked evidence of notification to the wound care NP, or PCP, regarding the resident's pain, vital signs, or changes of the wound.

Four days after the wound care NP's visit, night shift ULP noticed the resident was weak, confused, and had a change in behavior. ULP contacted the facility nurse, and the resident was sent to the emergency room. The resident returned to the facility a few hours later. Hospital records indicated the coccyx wound was assessed and the resident was prescribed a new antibiotic. The facility nurse was informed of the resident's return but did not assess the resident upon return to the facility. Later that day, ULP documented they changed the resident's bandage and contacted the nurse about concerns with the resident's condition and the nurse directed staff to check the resident's blood sugar. The resident told staff that she wanted to go to the hospital and staff contacted the nurse and sent the resident to the emergency room again. The nurse documented she spoke to hospital staff and expressed concern over the resident's wound and change in condition, but the resident was sent back to the facility with orders to continue with the antibiotic prescribed that morning and to follow up with the PCP next week. The nurse did not assess the resident upon her return to the facility.

Following the resident's return to the facility, ULP documented the resident was weak, could not feed herself, was not able to lift her head to take medication, and was not able to stand for transfers. Another ULP documented the resident's wound had a very strong odor and linens had to be changed due to the wound drainage. ULP documented the wound was "leaking a lot of brownish fluid" and told oncoming ULP staff to make sure they cleaned the wound properly and replaced the bandage. There was no evidence of the nurse being contacted after the resident's return to the facility.

The next day, ULP documented the resident could not open her mouth to take her pills and looked "completely out of it". ULP also documented the wound was "now the size of a golf ball and is oozing out brown stuff (possibly old blood) a lot." ULP documented they changed the dressing four times throughout the day due to the dressing being soiled. There was no documentation of ULP notifying the nurse of these concerns.

Later that day, ULP documented the resident was “not doing well” and that ULP repositioned, provided incontinent care, and changed the wound bandage every two hours. ULP documented that the resident asked for her family, so ULP contacted the resident’s family who requested for staff to send the resident to a different hospital emergency room for evaluation.

Emergency room notes indicated the resident had a very large, deep, oozing wound with brown purulent (pus) fluid and black tissue on the resident’s coccyx. The resident was given intravenous (IV) pain medication before staff cleaned and dressed the wound. When hospital staff applied pressure to the wound area, purulent (pus) material expressed out of the wound that had an odor and also started coming out of the resident’s vagina, making it suspicious for a fistula *(*an abnormal connection or passageway that connects two organs or vessels that do not usually connect). The wound measured 4 cm x 8 cm x 3-4 cm and was identified as a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) on the resident’s coccyx that extended deep into the muscle. The resident was started on IV antibiotics and transported via helicopter to a higher level of care with a diagnosis of septic shock and pressure ulcer of the coccyx.

During an interview, ULP stated they were not trained on how to complete the resident’s wound care and had to change the dressing many times due to the amount of drainage from the wound and the number of times the resident was incontinent of bowel and bladder. ULP stated there were no directions for how to complete wound care, so they made sure the wounds were clean and dressed. ULP stated the wound smelled sour and rancid. ULP stated they updated the nurse daily regarding the resident’s wound and change in condition and when they called the nurse regarding abnormal vital signs the nurse did not answer.

During an interview, the facility nurse stated wound documentation should have included additional detail and descriptions of the wound. The nurse stated staff were trained on wound care and signs and symptoms of infection, but the training was not documented. The nurse stated she was not aware of the wound drainage or odor until the evening prior to the resident being sent to the ER and was not aware of the resident’s abnormal vital signs. The nurse did not contact the wound care NP or the resident’s PCP after worsening of the wound or after the resident’s transfer to the emergency room.

During an interview, the wound care NP stated when she initially assessed the coccyx wound there was hardly any drainage and no odor. The NP stated she was not contacted about worsening of the wound but should have been contacted if the wound appeared worse, if there was odor, or if the dressing had to be changed multiple times due to drainage. The NP stated this was not the first time a wound had worsened at the facility, and she was not notified.

During an interview, the resident’s family member stated ULP informed her the resident was not doing well and thought the resident should be taken to a different hospital’s ER. The ULP told her how bad the wound was and how the staff were putting Vicks under their nose because

the wound smelled so bad. The family member stated the facility nurse did not contact her about concerns with the wound and the ER doctor told her if the resident hadn't been seen that day, she would have died. The family member stated the resident was flown to another hospital and hospitalized for three to four weeks before she was able to be discharged to a skilled nursing facility.

During an interview, the resident stated she did not remember anything from the last year due to being so sick.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

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

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means 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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Chippewa County Attorney
Montevideo City Attorney
Montevideo Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

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	21051	A. BUILDING: _____ B. WING _____	C 01/23/2024

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL210516905C/#HL210519225M On January 23, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 20 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL210516905C/#HL210519225M, tag identification 2320 and 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02320	Continued From page 1	02320		
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one residents (R1) with a wound and change in condition. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 15, 2023, with diagnoses including diabetes, obesity, and hidradenitis suppurativa (skin condition causing abscesses and scarring). R1's service plan dated July 17, 2023, indicated R1 required assistance with walking, bed mobility, dressing, toileting, transfers, and medication administration. The signed service plan did not	02320	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR	

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02320	Continued From page 2 include wound care. R1's 14 day assessment dated May 26, 2023, indicated R1 did not have impaired skin integrity and did not include interventions to prevent skin breakdown. R1's progress note dated August 7, 2023, unlicensed personnel (ULP) documented they put "pink stuff" on the resident's buttocks. R1's progress note dated August 8, 2023, included that ULP documented R1 complained of issues with her buttocks and Calmoseptine was applied and R1 was repositioned. R1's progress note dated August 9, 2023, included that ULP documented the resident requested an ointment since her bottom was raw from incontinent stools, bed had a large sink hole in the middle and a pillow was put in that spot. R1's 90 day assessment dated September 1, 2023, indicated R1 did not have impaired skin integrity. The assessment identified R1 had pain daily but not constant and could verbalize pain. There was no additional information regarding pain. R1's master care plan dated September 1, 2023, the skin diagram noted a (1) placed on the body diagram on the right heel area and a (2) placed on the diagram on the coccyx area. The notes identified the areas as "undefined". The record did not include an assessment of the skin concerns. The care plan did not include interventions or how often staff should monitor the areas. R1's progress note dated September 5, 2023,	02320	VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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02320	Continued From page 3 ULP documented coccyx and inner buttocks was looking sore again, and the resident laid on her side for an hour. R1's progress note dated September 28, 2023, ULP documented a heart shaped blister was noted on the resident's right heel. R1's progress note dated September 29, 2023, ULP documented a large blister on right heel that is swollen and filled with puss and bruising. R1's progress note dated October 2, 2023, a registered nurse (RN) documented the wound nurse saw the resident, will continue to elevate feet. R1's progress note dated October 11, 2023, ULP documented sore on butt crack is starting to bleed more, applied aquaphor on it. Physician order sheet dated October 11, 2023, included orders from the wound care nurse practitioner (NP) regarding the blister to right heel, apply betadine daily, then apply heel foam then secure with ace wrap, elevate legs as much as able. Will follow up in two weeks. There were no orders for the coccyx wound and no evidence of the wound care NP being notified of concerns with R1's coccyx area. R1's undated treatment and therapy plan did not include wound care and did not include the wound care NP orders for care of the wound. R1's progress note dated October 16, 2023, at 7:00 a.m., ULP documented resident had been on her light repetitively today and told staff she has wedgies and her bottom hurts or she has to use the bathroom. When staff brought the	02320		

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02320	Continued From page 4 resident to the bathroom the resident did not have a wedgie or did not use the bathroom. Staff reminded the resident that she had a sore bottom. The resident did not understand and kept pressing the call light. R1's progress note dated October 16, 2023, at 1:54 p.m., an ULP documented when turning the resident to the side staff noticed the wore on her bottom between her butt crack had turned black and was the size of a nickel. The ULP cleaned it and put on aquaphor. R1's progress note dated October 16, 2023, at 3:45 p.m., an ULP documented staff needed to use the lift again to get her out of bed. The resident said she was not feeling good and had diarrhea. Staff noticed the sore was black and kind of had a bad odor to it. R1's progress note dated October 16, 2023, at 4:27 p.m., the RN documented wound nurse was here and gave orders to clean the area and apply Calmoseptine and foam dressing. The area was swabbed. R1's wound assessment dated October 16, 2023, completed by the RN indicated R1 had a diabetic ulcer on the right heel, and a pressure injury on the coccyx. The assessment identified a wound nurse would be managing the wound. The assessment did not include an a description of the wound or measurements of the wound. The assessment did not indicate if the wounds caused pain for R1. R1's physician order sheet dated October 16, 2023, indicated heel wound: clean well, foam, change Monday, Wednesday and Friday. Buttock wound culture pending, calamine and foam	02320		

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02320	Continued From page 5 change daily, turn and reposition every 1-2 hours. Hospital records dated October 16, 2023, indicated the resident was seen for follow up for a right heel blister. The resident also developed an open area on her coccyx. The resident reported she is not able to get out of bed much. The resident reports pain with her heel and buttock wound. The resident feels she could use a better mattress. The stage 2 pressure ulcer of the coccyx region with measurements 0.2 cm x 1.7 cm, x 1 cm filled with some necrotic tissue, surrounding redness and moderate serosanginous drainage. The edges were intact and there was no odor. Orders for buttock wound: clean with normal saline, apply Calmoseptine to the wound peri-area, apply aquacel ag 2 x 2 to the open area, apply foam zetuvit 2 x 2 pad with 4 x 4 adhesive board to cover the area and change daily. R1's progress note dated October 16, 2023, at 10:00 p.m., ULP documented she placed a bandage on R1's coccyx. The area was dark in color, oozing, and was painful. R1's progress note dated October 16, 2023, at 11:00 p.m., ULP documented R1 was changed four times, and repositioned every 2 hours. The ULP placed a silicone bandage to help soak oozing liquid coming of the resident's coccyx and puss was squirting from the wound. The resident was dizzy so vital signs were taken at 2:00 a.m., blood pressure 96 (normal blood pressure 120/80), temperature- 99.8, oxygen 91, respirations 18, pulse 93. At 4:00 a.m., temperature- 98.9, oxygen saturation 93, respirations-18, pulse- 98. R1's progress note dated October 17, 2023, at	02320		

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02320	Continued From page 6 2:00 a.m., ULP documented R1 was dizzy, and vital signs were 99.8, 93, 19, 96/53. The sponge bandage was soaking up all the liquids that were leaking out [of coccyx wound]. R1's progress note dated October 17, 2023, at 5:00 a.m., ULP documented the resident was still dizzy, 98.9, 98, 18, 83/48. R1's progress note dated October 17, 2023, at 3:38 p.m., ULP documented the resident was having more troubles getting up and could not really stand anymore and had to use the lift again and R1's sore was looking worse. R1's progress note dated October 17, 2023, at 5:29 p.m., RN documented wound clinic called and ordered Bactrim (antibiotic) and the culture was pending. R1's physician order sheet dated October 17, 2023, indicated an order for Bactrim DS 800-160 milligram (mg) twice daily for 10 days. R1's progress note dated October 20, 2023, at 8:30 a.m., RN documented staff called at 1:10 a.m., and said the resident was confused and not able to answer questions. The resident was at the emergency room for 1.5 hours and a new antibiotic was ordered. R1's progress note dated October 20, 2023, at 8:45 p.m., RN documented the hospital called to follow up and the RN voiced concerns regarding the resident being sent back to the facility as the resident was not at baseline and was not able to walk or hold a conversation. The ER medical doctor indicated to have her seen next week or if she has a temperature to send her back. The RN documented she was concerned there was more	02320		

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02320	Continued From page 7 going on with the wound. R1 was not assessed by the RN upon her return to the facility. R1's progress note dated October 20, 2023, at 4:42, RN documented R1 did not feel well and wanted to be seen. The resident was transferred to the ER after lunch. At 4:30 p.m., the RN called the ER and the ER nurse stated they were sending her back and to continue the antibiotic. The RN questioned if labs had been completed and the nurse said R1 wanted to come back to the facility and labs were not done. The ER sent R1 back without lab work. R1 was not assessed by the RN upon her return to the facility. R1's record did not include documentation regarding the wound on October 18, and October 19, 2023. R1's progress note dated October 21, 2023, a 5:13 a.m., ULP documented a strong odor emitting from the wound. R1's progress note dated October 21, 2023, at 4:15 p.m., RN documented R1 was sent to another ER due to family member's request and was transferred to a higher acuity hospital. R1's Planned Service Document indicated R1 received two skin treatments but did not specify what part of the body the skin treatment should be applied. The plan did not include step by step instructions for staff for the skin treatments nor did it include when to contact a nurse if there were changes to the area.	02320		

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HOME FRONT FIRST	224 NORTH 19TH STREET MONTEVIDEO, MN 56265

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02320	Continued From page 8 R1's Emergency Room (ER) records dated October 20, 2023, indicated R1 was seen twice in the ER and was sent back to the facility without labs being completed. A new order for Doxycycline (antibiotic) was started. The first time the coccyx wound was assessed by hospital staff, the second time the coccyx wound was not observed. R1's ER record dated October 21, 2023, indicated R1 was seen at another hospital ER prior to being brought to this ER. When ER staff rolled R1 over they noticed a very large, deep, oozing of brown fluid, purulent fluid, and black tissue on R1's coccyx. R1 was a given intravenous (IV) pain medication so staff could clean and dress the wound. With pressure applied to the area purulent material was expressed with malodorous fluid and also starting coming out of R1's vagina making it suspicious for a fistula. The wound measured 4 cm x 8 cm x 3-4 cm. The wound was a large stage 4 pressure ulcer on the coccyx that extended deep into the muscles. R1's blood pressure was initially mid 90/60's and would drop to 80's/30's and then dropped to 70's/40's. Labs completed showed an increased white blood count (WBC), and R1 was started on an IV antibiotic. R1 was transferred via helicopter to a higher level of care with diagnoses of septic shock and decubitus ulcer (pressure ulcer) on the coccyx stage 4. On January 31, 2024, at 10:00 a.m., ULP-F stated R1's wound started out like a pimple and then was black and oozing brown stuff. ULP-F stated she reported these concerns to the nurse daily when she worked. The nurse told her to keep it clean and keep an eye on it. ULP-F stated she had to change the dressing multiple times because R1 was incontinent of bowel and	02320		

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02320	Continued From page 9 bladder. ULP-F stated she was not trained on how to complete R1's wound care. ULP-F stated there was no training or re-education after this incident. On January 21, 2024, at 1:00 p.m., ULP-H stated she rolled R1 over to clean her and liquid squirted out of R1's coccyx, ULP-H washed the area with saline and put another bandage on. ULP-H stated the wound was pretty big and we needed to find something spongy for a dressing. ULP-H stated the wound smelled sour, rancid, and it was not a good smell. ULP-H stated the nurse knew about the odor and this information was past on to the morning shift. ULP-H stated she called the nurse about R1's abnormal vital signs, but the nurse did not call back. ULP-H stated she did not receive training for R1's wounds and there was no directions for how to care for the wound. ULP-H stated she found a dressing in the medication room and stated for certain wounds, "you just kind of dress them and make them clean," and during the day they can take if from there. ULP-H stated there was no training or re-education after the incident. ULP-F and ULP-H's employee records reviewed did not include training or competencies for the are of R1's wound. There was also no training or re-education completed following R1's transfer out of the facility. On January 26, 2024, at 2:00 p.m., RN-D stated R1's assessment completed on September 1, 2023, should have included a description of the areas of concern for R1's skin. RN-D stated on September 1, 2023, R1's right heel was purple or black in color, and R1's buttocks was macerated, but this was not documented. RN-D stated she should have updated R1's treatment plan, service	02320		

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02320	Continued From page 10 plan, and should have completed a change of condition assessment. RN-D stated she trained staff on how to complete R1's skin treatments but did not document that training and was not aware competencies had to be completed. RN-D stated she trained staff on signs and symptoms of infection in a wound or when to contact a nurse but also did not document the training. RN-D stated she was not aware of odor or drainage coming from the wound until the evening of October 19, 2023. RN-D stated she was also not aware of R1's abnormal vital signs. RN-D did not contact R1's primary care provider (PCP) or the certified nurse practitioner (CNP) who provided wound care for the facility, after R1 was sent back from the ER the first time. On January 23, 2024, at 1:15 p.m., RN-A stated if impaired skin integrity was noted the nurse should look at the area, measure it and document in the progress notes. RN-A stated she did not complete the an internal investigation and thought maybe the facility nurse did. RN-A stated she had not reviewed R1's record prior to the MDH investigator's onsite visit. RN-A also stated wound care training and competencies should be completed by a RN. RN-A did not know if employees were trained to provide R1's wound care. On January 25, 2024, at 1:16 p.m., the wound care certified nurse practitioner (CNP)-C stated she saw R1 on October 11, 2023, for a right heel blister and on October 16, 2024, for an unstageable wound on R1's coccyx. CNP-C stated R1 was in pain during the dressing change. CNP-C stated when she initially saw the coccyx area there was a little open area, hardly any drainage, and it did not have an odor. CNP-C stated every wound should be assessed by a	02320		

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02320	Continued From page 11 nurse. CNP-C stated she was not contacted by the facility after her visit on October 16, 2023, but should have been if the wound was worse, had odor, or the dressing had to be changed multiple times due to drainage. CNP-C stated this was not the first time wounds had worsened in this facility and they were not notified. On January 31, 2024, 8:30 a.m., R1's family member (FM)-E stated R1 was seen twice at the local ER and was not aware R1 could be transported to another ER, and wished R1 would have been sent to another ER sooner. FM-E stated ULP called her on October 21, 2023, and told her R1 should be transferred to another ER. FM-E arrived at the facility on October 21, 2023, and the ULP informed her how bad the wound was and how big it had gotten. FM-E stated the ULP's were putting Vicks under their nose since the wound smelled so bad. FM-E stated the nurse did not contact her about concerns with the wound. FM-E stated the ER doctor told her if R1 was seen one day later, R1 would have died. R1 had to be flown to a higher level hospital and was hospitalized for about three to four weeks before being transferred to a skilled nursing facility. On January 31, 2024, at 11:00 a.m., R1 was interviewed and stated she did not remember anything in the last few months since she was so sick. The licensee's Change in Condition policy dated August 1, 2021, indicated when changes in condition or need are identified, a RN will initiate a change in condition assessment. The site will communicate with the resident or resident's representative to determine if the recommended change will be added to the service plan. Change in condition assessment will also be initiated after	02320		

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02320	Continued From page 12 every resident readmission to the site from the hospital, emergency department or other medical/treatment stay. The licensee's Treatment and Therapy Management Plan dated August 1, 2021, indicated for each resident receiving management of ordered or prescribed treatment or therapy services the licensee will prepare and include in the service plan a written statement of the treatment or therapy service. The plan must include a statement of the type of services that will be provided, documentation of specific resident instructions relating to the treatment or therapy administration, identification of treatment or therapy tasks that will be delegated to unlicensed personnel, procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatment or therapy services, any resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The licensee's Competency Training Evaluations dated August 1, 2021, indicated a RN will determine what nursing services may be delegated to properly trained and competency tested ULP. Only ULP who are determined to be competent and possess the knowledge and skills consistent with the complexity of the tasks being delegated with be permitted to perform such delegated tasks. Tasks the require competency testing by a RN include wound care. Competency may be demonstrated via written, oral or practical test of the skill and a copy of all education, training and competency testing shall by kept in each personnel file.	02320		

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02320	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	