MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:	Report Number:	Date of Visit:
Cottage Grove White Pines II	HL27918002	June 3, 2016
Facility Address:	**Time of Visit:**	**Date Concluded:**
6950 East Point Douglas Road South	9:00 a.m.- 4:30 p.m.	August 23, 2016
Facility City:	**Investigator's Name and Title:**	
Cottage Grove	Rhylee Gilb, RN Special Investigator	

State:	ZIP:	County:
Minnesota	55016	Washington

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is alleged that a client was neglected when s/he developed a stage four pressure ulcer while at the facility.

☒ 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 staff failed to assess a client for a decline in condition and for skin concerns, which resulted in the client developing pressure ulcers. The client experienced a large sacral (upper buttock) pressure ulcer and a pressure ulcer on each of his/her heels. These wounds were not promptly addressed or treated. In addition, the client was not re-assessed after a significant weight loss.

The client had received services from the home care provider for three months. The client required assistance of one person with toileting every two hours, reassurance checks every two hours, shower with a skin check twice a week, dressing/grooming twice a day, and ambulation/escorts. During the client's three month stay, the client experienced a decline in physical strength and was no longer able to ambulate. Approximately two months after admission, the client experienced a forty pound weight loss.

Ten days prior to discharge, an unlicensed staff member notified the registered nurse (RN) of the client's skin concerns, observed during a bath, related to his/her sacrum and heels. The concerns were signed off by the RN, however an assessment was not completed. Two days prior to discharge, the RN observed the areas of concerns due to reports of the sacrum having an open wound. The RN updated the client's physician regarding a wound to his/her buttocks and right heel. Orders were received for wound care services from an outside agency. The following day the RN initiated heel protectors to be worn by the client. On the day of the client's discharge, the RN completed a wound assessment with the agency wound care nurse. The wound care nurse determined the client required hospitalization due to possible infection. The client transferred to the hospital, required surgical debridement of a large sacral ulcer and required a wound

vacuum for treatment, as well as intravenous antibiotics for infection. The client also had a large ulcer on his/her right heel and a smaller ulcer on the left heel. The client continued to decline and died thirty-two days later. The cause of death was listed as Alzheimer's.

During interviews, unlicensed staff stated the client had redness of the sacral area for several weeks prior to the client's hospitalization. Staff stated the nurses were updated, the client was repositioned every two hours, and cream was applied to area.

During an interview, the RN stated the client's sacrum was for red three to four days prior to it opening. The day the RN observed the wound, s/he described the wound as about the size of an eraser. The RN also stated the client was repositioned every two hours and it was standard to reposition all clients at that frequency. The RN stated s/he usually assesses skin concerns on the bath sheets, but did not recall doing a follow up or assessment of the initial skin concern. The RN also explained that clients' weights are reviewed by a nurse at the end of each month, however this client's forty pound weight loss was missed. A nutritional supplement was started because the client's appetite was poor. The RN stated a significant weight loss would warrant a change in condition assessment, but one was not completed.

During an interview, the hospital wound surgeon stated the sacral wound appeared chronic and there was no fast growing bacteria present that would cause rapid deterioration. The client was evaluated by the surgeon and underwent surgical debridement two days after hospital admission. The surgeon described the wound as large, ten centimeters (cm) by fifteen cm with necrotic (black, dead) tissue and undermining. The wound was infected with multiple organisms. The surgeon stated the wound could not have transitioned from a pinpoint opening to a large open wound in thirty-six to forty-eight hours.

During an interview with the client's family, the family member stated s/he was not made aware of the pressure ulcer by the home care provider until the day of discharge. The family member explained the agency wound care nurse described the wound as severe and the client required hospitalization. At the hospital, the family member was made aware by hospital staff that the client experienced a forty pound weight loss. After the surgery, the family member stated the surgeon described the wound as about the size of a grapefruit with depth to the bone.

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 failed to ensure an assessment was completed when nursing was notified of a red area to the

clients coccyx, and also failed to ensure any comprehensive assessment was completed when the client experienced a forty pound weight loss in two months. The wound specialist stated the wound could not have deteriorated rapidly in two days, and had signs of being chronic.

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 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 for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(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:

- ☒ Medical Records
- ☒ Weight Records
- ☒ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Treatment Sheets
- ☒ Skin Assessments
- ☒ Therapy and/or Ancillary Services Records
- ☒ Service Plan

Other pertinent medical records:

☒ Hospital Records ☒ Death Certificate

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: two

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: client is deceased

Interviews: The following interviews were conducted during the investigation:

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

Specify: _____

If unable to contact complainant, attempts were made on:

Date:	Time:	Date:	Time:	Date:	Time:

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

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

○ Yes ○ No ◉ N/A Specify: _____

Did you interview additional residents? ○ Yes ◉ No

Total number of resident interviews: _____

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

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: ten

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:

☒ Cleanliness

☒ 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

Washington County Attorney

Cottage Grove City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27918	A. BUILDING: _____ B. WING _____	R-C 10/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COTTAGE GROVE WP II LLC	6950 EAST POINT DOUGLAS ROAD S COTTAGE GROVE, MN 55016

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{0 000}	Initial Comments A licensing order follow-up was completed to follow up on correction orders issued related to complaint HL27918002. Cottage Grove WP II LLC was found in compliance with state regulations.	{0 000}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 16, 2017

Ms. Rhonda Schillinger, Administrator
Cottage Grove White Pine II LLC
6950 East Point Douglas Road S
Cottage Grove, MN 55016

RE: Complaint Number HL27918 002

Dear Ms. Schillinger :

On October 9, 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 August 10, 2016 with orders received by you on October 5, 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,

John Aglieco
Health Program Representative-Senior
Minnesota Department of Health
85 East Seventh Place, Suite 220
PO Box 64970
St Paul, MN 55164-0970
Office 651-201-4212 Fax: 651-281-9796

ja
Enclosure

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

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On 06/03/2016, a complaint investigation was initiated to investigate complaint #HL27918002 . At the time of the survey, there were 43 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.	
0 265 SS=G	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing	0 265		

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0 265	Continued From page 1 standards, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on interview and document review the licensee staff failed to provide cares with an adequate service plan for one of three clients (C1) and the client developed a pressure ulcer. This practice resulted in a level three violation (a violation that harmed a client'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 is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on 2/4/16 with diagnoses that included dementia, depression, and chronic kidney disease stage IV. C1's service plan dated 2/4/16 indicated C1 required assistance of one person for dressing/grooming, toileting every two hours, bathing and assistance of one to two people for ambulation. C1 also required medication assistance and reassurance checks every two hours. C1's medication administration record (MAR) was reviewed. C1's weight on 2/25/16 was 210 pounds and the next weight recorded was on 3/24/16, with a weight of 168 pounds, a difference of a thirty-eight pound loss. There were no weights obtained in April 2016. On 4/11/16 Ensure, one can three times a day was started.	0 265		

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0 265	Continued From page 2 Licensee skin audit sheets reviewed for C1 were reviewed. Weekly skin audits were completed on bath days by unlicensed staff and reviewed by the registered nurse (RN). On 4/3/16, the skin audit indicated a red sore was found on C1's coccyx. The skin audit was signed by RN-B. On 4/10/16, the skin audit indicated C1 required a sponge bath due to sores on heels of both feet. C1's nursing notes and nursing assessments dated 2/4/16 through 4/13/16, were reviewed. There was no documentation an RN assessed C1 for weight loss. There was no documentation an RN assessed C1's skin after the documentation on 4/3/16 of a sore noted on her coccyx by the unlicensed personnel. There is also no documentation of a significant change assessment completed by a RN for either the weight loss and the skin breakdown. The service plan was also not updated to meet the nutritional and positioning needs required by C1. During an interview on 6/3/16, at 3:35 p.m., unlicensed personnel (ULP)-E stated C1 started with small sores on both her coccyx and foot. ULP-E stated both of the nurses were updated, but ULP-E was not aware if they had assessed the areas. ULP-E explained the unlicensed staff were to put a cream on C1's coccyx and reposition every hour. In addition, ULP-E stated staff was directed to put a pillow under C1's foot to relieve pressure as well. ULP-E stated C1 was in pain a lot and mostly complained from pain related to the foot wound. During an interview on 6/7/16, at 2:15 p.m., ULP-I stated she completed the bath on 4/3/16 and first noted C1's coccyx was red and sore. ULP-I stated the area was not open at the time and staff	0 265		

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0 265	Continued From page 3 applied cream and powder. Also, ULP-I said she updated both of the nurses verbally, in addition to the documentation on the skin audit sheet. During an interview on 6/3/16, at 1:45 p.m., licensed practical nurse (LPN)-C stated she was first notified on 4/10/16 C1 had a open sore on her coccyx. On 4/11/16, LPN-C stated in tandem with RN-B, they observed a red coccyx and a small open area about the size of the end of a pen. LPN-C stated a note placed in the treatment sheet communicated to ULP staff to reposition C1 from side to side every hour. LPN-C stated she was unsure if RN-B had completed an assessment. LPN-C explained typical process for concerns is to document in the chart notes and update the physician. During an interview with RN-B on 6/22/16, at 2:35 p.m. RN-B stated the practice for nurse review of the skin audit is to assess any area of concern noted by the unlicensed staff. RN-B stated if the 4/3/16 skin audit indicated there was a sore on C1's coccyx she would have assessed the area, but does not recall doing so. RN-B also stated the client's weights are reviewed monthly at the end of each month or if the licensee nurses are aware of a client's poor appetite. RN-B stated C1's appetite was poor, so she ordered Ensure supplements. RN-B stated C1's almost forty pound weight loss in one month was missed during review. RN-B stated that poor appetite and a forty pound weight loss would indicate a significant change. The licensee policy titled "Initial and On-going Nursing Assessments of Clients" dated 8/27/14, indicated the registered nurse (RN) will reassess the client any time the client has a change in condition. The RN will review the client's service	0 265		

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0 265	Continued From page 4 plan, evaluate the clients medication and treatments, communicate any concerns to the client's physician and update the service plan as necessary. TIME PERIOD FOR CORRECTIONS: 21 days.	0 265		
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to assess and provide intervention when skin concerns were documented for one of three clients (C1) and the client developed a pressure ulcer. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on 2/4/16 with diagnoses that included dementia, depression and incontinence. The service plan dated 2/4/16 indicated C1 required assistance with toileting	0 325		

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0 325	Continued From page 5 every two hours, reassurance checks every two hours, shower with a skin check twice a week, dressing/grooming twice a day and ambulation/escorts. A licensee management note to staff dated 2/4/16, alerted staff that C1 had not been eating well prior to admission. C1's medication orders indicated C1 required weekly weights. C1's admission registered nurse (RN) assessment dated 2/4/16 indicated there were no issues with skin integrity. The RN fourteen day assessment dated 2/18/16, specified C1 had scratch marks on her legs and arms. C1's shower skin check sheets were reviewed. On 4/3/16 unlicensed personnel (ULP)-I documented C1 had a sore in the upper crack of her buttock. ULP-I applied powder. The RN signed the sheet, but did not date when signed. On 4/10/16, ULP-J documented C1 required a sponge bath due to sores on heels of both feet. The RN also signed the sheet, but again did not date the signature. The medication administration record (MAR) dated April 2016, indicated heel protectors to be worn while C1 was up had initiated on 4/12/16. The nursing order does not specify on which heel the protectors needed to be worn. C1's weight on 2/25/16 was two hundred ten pounds and on 3/24/16 was one hundred sixty-eight pounds, a thirty-eight pound weight loss. There were no other documented weights on C1's MAR dated February 2016, March 2016 and April 2016. Review of C1's fax communication indicated on 4/11/16, the RN sent a fax to the physician notifying him of blisters on C1's right heel and an open area on her buttocks and requesting a referral to home care for wound care. Also on	0 325		

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0 325	Continued From page 6 4/11/16 the RN sent a fax to a home care agency requesting wound care services and indicated there was a phone conversation between the licensee RN and the home care agency. C1's wound assessments dated 4/13/16, indicated C1 had a oblong four centimeter (cm) by five cm full thickness (damage to muscle or bone) wound to her sacrum. There was undermining involving more than half of the wound edges. The wound bed had between fifty percent and seventy-five percent necrotic (black, dead) tissue with drainage. C1's right heel had a round four cm diameter, partial thickness (damage to the skin, but not as deep as the muscle) wound. There was a large amount of drainage. C1 was transferred to the hospital on 4/13/16. Upon admission, she had a temperature of 101.9 and was treated with intravenous antibiotics. On 4/14/16, C1 was evaluated by the wound surgeon. The sacral pressure ulcer measured four cm by almost three cm and was one and half cm deep. There was necrotic tissue and large amount of green/brown drainage. The right heel ulcer was nine and half cm by ten cm or black, necrotic tissue and no drainage. The left heel also had a pressure ulcer measuring three cm by two cm also black/necrotic tissue and no drainage. C1 experienced surgical debridement of the infected sacral ulcer on 4/15/16. After debridement the sacral ulcer measured ten cm by twelve cm and required a wound vacuum for healing. Wound cultures were also obtained of the sacrum and found multiple bacteria. C1 was discharged from the hospital on 4/19/16 to a transitional care facility and died on 5/13/16.	0 325		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 325	Continued From page 7 During an interview with the hospital wound surgeon on 8/10/16, at 3:30 p.m. the surgeon stated the sacral wound appeared chronic and there was no bacteria present that would be fast growing and cause quick deterioration. He stated the wound could not have transitioned from a pinpoint opening to a large open wound in thirty-six to forty-eight hours. On 6/3/16, at 3:35 p.m. during an interview with ULP-E she stated she first noticed a sore on C1's bottom approximately four weeks prior to C1's hospitalization. ULP-E said the sore presented as red mark and the nurses were updated. ULP-E stated the nurses informed ULP staff to apply a cream to the area and reposition C1 to avoid pressure to the sacrum. An interview with ULP-I on 6/7/16, at 2:15 p.m. ULP-I stated during C1's bath on 4/3/16 C1's sacrum was red, but not open. ULP-I said both nurses were made aware and applied ointment and powder to the area. During an interview with licensed practical nurse (LPN)-C on 6/3/16, at 1:45 p.m. LPN-C stated she was first notified on 4/10/16 C1 had a open sore on her coccyx. On 4/11/16, LPN-C stated she observed the area along with RN-B. LPN-C stated they observed a red coccyx and a small open area about the size of the end of a pen. LPN-C stated a note placed in the treatment sheet communicated to ULP staff to reposition C1 from side to side every hour. On 4/12/16, LPN-C stated the open area was bigger and on 4/13/16 it was the size of a quarter. LPN-C stated there was no odor associated with the wound. On 6/22/16, at 2:35 p.m. during an interview with RN-B, she stated C1's coccyx was red three to	0 325		

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0 325	Continued From page 8 four days prior to it opening on 4/11/16. RN-B stated on 4/11/16, the opening was about the size of an eraser and there was some foul odor to it. She stated C1 was repositioned every two hours and it was standard to reposition all clients at that frequency. RN-B stated that usually she assesses skin concerns on the bath sheets, but did not recall doing a follow up on the documentation of a coccyx sore on 4/3/16 bath sheet. RN-B explained usually she, and LPN-C, reviewed the weights at the end of each month, but C1's forty pound weight loss was missed. However, RN-B stated she was aware C1's appetite was poor, and she had started ensure for C1. RN-B stated she tries to document changes in the nursing notes, but with forty-five clients sometimes things slip through the cracks. The licensee policy titled "Initial and On-Going Nursing Assessments of Clients" dated 8/27/14, indicated the RN will reassess a client any time the client has a change in condition and will review the client's service plan, evaluate treatments, communicate new problems or concerns to the client's physician and update the service plan as necessary. The licensee policy titled "Skin Care and Wound Care" dated 10/30/15, indicated staff will monitor skin integrity at every possible interaction the skin is visible and report any changes or concerns to inuring. The nurse will assess the skin by completing a wound assessment and will implement and delegate wound care orders as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		

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0 860	Continued From page 9	0 860		
0 860 SS=G	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to complete a comprehensive assessment for a change in a client's condition for one of three clients (C1) reviewed, when the client experienced a thirty-eight pound weight loss	0 860		

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0 860	Continued From page 10 in one month and developed a pressure ulcer. This practice resulted in a level three violation (a violation that harmed a client'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 is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee policy titled "Initial and On-going Nursing Assessments of Clients" dated 8/27/14, indicated the registered nurse (RN) will reassess the client any time the client has a change in condition. The RN will review the client's service plan, evaluate the clients medication and treatments, communicate any concerns to the client's physician and update the service plan as necessary. If a referral is necessary, the RN will inform the client and/or the client's representative. C1's medical record was reviewed. C1 was admitted to the licensee on 2/4/16 with diagnoses that included dementia, depression, and chronic kidney disease stage IV. C1's service plan dated 2/4/16 indicated C1 required assistance of one person for dressing/grooming, toileting every two hours, bathing and assistance of one to two people for ambulation. C1 also required medication assistance and reassurance checks every two hours. There was no comprehensive assessment in C1's record for a change in condition. C1's medication administration record (MAR) was reviewed. C1's weight on 2/25/16 was 210 pounds and the next weight recorded was on 3/24/16, with a weight of 168 pounds (a loss of	0 860		

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0 860	Continued From page 11 thirty-eight pounds). There were no weights obtained in April 2016. On 4/11/16 Ensure, one can three times a day was started. On 4/12/16 an intervention started for C1 to wear heel protectors while sitting up. Licensee skin audit sheets were reviewed for C1. Weekly skin audits were completed on bath days by unlicensed staff, and reviewed by the registered nurse (RN). On 4/3/16 the skin audit indicated a red sore was found on C1's coccyx. This was signed by RN-B. C1's nursing notes and nursing assessments dated 2/4/16 through 4/13/16 were reviewed. There was no documentation an RN assessed C1 for weight loss. There is no documentation an RN assessed C1's skin after unlicensed personnel documented a sore on C1's coccyx on 4/3/16. There is also no documentation of a significant change assessment completed by a RN for weight loss and a skin breakdown. A physician communication form dated 4/11/16, indicated RN-B communicated verbally to the physician that a blister to C1's right heel and an open area on her buttocks were discovered. The physician gave verbal orders to refer C1 to home care for wound care. During an interview with C1's family member on 6/13/16 at 2:20 p.m., the family member stated the licensee did not inform family of a pressure ulcer and the outside agency wound nurse gave an update on 4/13/16 when consent was needed to send C1 to the hospital. During an interview on 6/3/16 at 1:45 p.m., licensed practical nurse (LPN)-C stated unlicensed staff first updated her on an open area	0 860		

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0 860	Continued From page 12 on C1's coccyx on 4/10/16 and LPN-C instructed staff to reposition C1 side to side, not laying her on her back. On 4/11/16, LPN-C along with RN-B observed the area. LPN-C stated the pressure ulcer was the size of a pen and slightly red around the opening. During an interview on 6/22/16 at 2:35 p.m., RN-B stated C1 had a red area on her coccyx three to four days prior to it opening on 4/11/16, and RN-B was watching the area closely. She stated the standard at the licensee to reposition clients was every two hours, C1 included. RN-B stated C1 was incontinent of both bowel and bladder and would at times scratch at the sore on her coccyx. RN-B stated the practice for nurse review of the skin audit is to assess any area of concern noted by the unlicensed staff. RN-B stated if the 4/3/16 skin audit indicated there was a sore on C1's coccyx she would have assessed the area, but does not recall doing so and there is no documentation in the nurse notes indicated the area was assessed. RN-B also stated the client's weights are reviewed monthly at the end of each month or if the licensee nurses are aware of a client's poor appetite. RN-B stated C1's 40 pound weight loss in one month was missed during review. RN-B stated C1's appetite was poor and started Ensure supplements. RN-B stated that poor appetite and a 40 pound weight loss would indicate a significant change. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 860		
01045 SS=D	144A.4793, Subd. 5 Documentation of Treatment/Therapy	01045		

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01045	Continued From page 13 Subd. 5. Documentation of administration of treatments and therapies. Eachtreatment or therapy administered by a comprehensive home care provider must be documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to provide documentation of weekly weights for one of three clients (C1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on 2/4/16 with diagnoses that included dementia, depression, and chronic kidney disease stage IV. C1's physician orders dated 2/4/16 indicated an order for weekly vital signs and weights for health maintenance.	01045		

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01045	Continued From page 14 C1's medication administration record (MAR) dated monthly February 2016, March 2016 and April 2016 was reviewed. The weight was to be recorded weekly on Thursdays. C1's weights were recorded as follows: 2/11/16: no weight recorded 2/18/16: no weight recorded 2/25/16: weight recorded, two-hundred ten pounds 3/3/16: no weight recorded 3/10/16: no weight recorded 3/17/16: no weight recorded 3/24/16: weight recorded, one-hundred sixty-eight pounds 3/31/16: no weight recorded 4/7/16: no weight recorded During an interview on 6/22/16, at 2:35 p.m., registered nurse (RN)-B stated she was not aware of weight loss, but was aware C1 was not eating much. RN-B started a nutritional supplement (ensure). RN-B stated the scale was variable and forty pounds would be a significant change. RN-B explained protocol was to review weights at the end of the month or if a client is not eating. RN-B stated C1's weight loss slipped through the cracks. The licensee policy titled "Monitoring of Clients and Their Services" dated 8/27/14, indicated the RN will monitor clients' needs and services on an ongoing basis to determine if services are appropriate to the client's needs. The RN will evaluate the effectiveness of the services, medications and treatments; and identify any changes in condition. TIME PERIOD FOR CORRECTION: Twenty-one	01045		

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01045	Continued From page 15 (21) days	01045		
01080 SS=D	144A.4794, Subd. 3 Contents of Client Record Subd. 3. Contents of client record. Contents of a client record include the following for each client: (1) identifying information, including the client's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified; (3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) client's advance directives, if any; (6) the home care provider's current and previous assessments and service plans; (7) all records of communications pertinent to the client's home care services; (8) documentation of significant changes in the client's status and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (9) documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan;	01080		

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01080	Continued From page 16 (11) documentation that the client has received and reviewed the home care bill of rights; (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to document changes in the client's status, interventions, treatments provided, and communication pertinent to the client for one of three clients (C1) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1's medical record was reviewed. C1 was admitted to the licensee on 2/4/16 with diagnoses that included dementia, depression, and chronic kidney disease stage IV. C1's service plan dated 2/4/16 indicated C1 required assistance of one	01080		

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01080	Continued From page 17 person for dressing/grooming, toileting every two hours, bathing and assistance of one to two people for ambulation. C1 also required medication assistance and reassurance checks every two hours. On 6/22/16, at 2:35 p.m. during an interview, the registered nurse (RN)-B stated C1 was not eating much and started receiving a nutritional supplement. RN-B also indicated C1 did not ambulate, spent most of her time in bed and favored laying on her right hip. RN-B stated on 4/11/16 a small wound, the size of an eraser, opened on C1's coccyx. The area was red, with not much blanching, a small amount of drainage, and some foul smell. There was no depth that RN-B could tell at that time. She stated she cleansed the wound with a wound cleanse and covered the wound with a four by four with adhesive border dressing. RN-B also stated three or four days prior the area was red, but had no open wounds. RN-B stated nursing does try to document in the nursing notes however, sometimes things get missed and slip through the cracks with forty-five clients. C1's nursing notes dated 2/4/16 through 5/16/16 contained five notes. On 2/4/16, a note indicated C1 was admitted to the licensee. On 3/3/16, a note explained a fall C1 experienced. On 4/13/16, two notes indicated C1's family was updated on a decline in condition and about her wounds, and also indicated C1's physician was notified. The second note explained that C1 was transferred to the hospital for possible wound infection. On 5/16/16, the last note indicated C1 had passed away. There were no other notes describing the change in appetite, physical status, wound assessment or interventions provided by RN-B as she indicated.	01080		

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01080	Continued From page 18 During an interview on 6/3/16, at 1:45 p.m., licensed practical nurse (LPN)-C stated she observed C1's coccyx on 4/11/16, 4/12/16 and 4/13/16 after she received report from unlicensed staff there was an open area. LPN-C stated she was unsure if RN-B documented the wound evaluation or the treatment provided in the nursing notes. LPN-C affirmed there were no previous notes in the record prior to 4/13/13. LPN-C stated upon first observation of a wound, protocol is to chart in the care notes, update the physician and obtain orders for treatment. The licensee's policy titled "Contents of Client Records" dated 8/22/14 indicated the clients record will contain all records of communication pertinent to the client's services and documentation of significant changes in the client's status and actions taken in response. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01080		