MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
KCMG Highland Park LLC
750 Mississippi Boulevard
St. Paul, Minnesota 55116
Ramsey County

Report#: HL29564001

Date: June 24, 2016

Date of Visit: October 14, 2015
Time of Visit: 8:30 a.m. – 3:30 p.m.

By: Lisa Jacobsen, RN, Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a client was neglected when the facility failed to follow the physician's orders regarding wound care and also did not provide adequate personal cares for the client. The facility was not tracking the treatment of the wound care. The client's wound has worsened.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, neglect of health care occurred when the facility failed to provide the necessary care and treatment for the client's sacral wound on a consistent basis, which contributed to the client's wound worsening and requiring the client to be hospitalized.

The client was admitted to the facility with a sacral ulcer that measured two centimeters by one centimeter. The client was incontinent of urine and required assistance with toileting and stand-by assist with ambulation.

The client had physician's orders on admission for daily wound care that included applying a wound product and covering the wound with a dressing. An outside home care agency was also involved in providing the wound care three times a week. There was no evidence the licensee coordinated the treatment of the client's wound with the outside home care agency to ensure that the wound treatment was done on a daily basis. There was no evidence that the licensee completed the client's wound treatment for the first seven days the client was as the facility. The outside home care agency completed the client's wound care two times during the first seven days.

The client's care plan on admission identified the client had an open area to left of the midline, but lacked direction to staff to assist/remind the client to keep off the open area to relieve pressure to the area.

The client's admission assignment sheet that the direct care staff used to know what care they needed to provide for the clients under skin care, indicated staff were to watch for redness and report to nursing right away, but did not indicate that the client had an ulcer on her sacral area.

The nurse practitioner saw the client's wound seven days after the client was admitted to the facility and noted the client's sacral ulcer had increased in size since admission, was soiled with stool and urine and no dressing was in place. The client's wound treatment was changed to start every three hours (not overnight hours) cleansing of the area if soiled with stool/urine) and applying a protectant barrier cream. The order also indicated the client needed assistance with the changing of the client's incontinence product every three hours if soiled as well.

There was no evidence that every three hour cleansing the open area and applying a protective cream was implemented on a consistent basis by the facility. The facility communicated to staff on the "Daily Log", regarding the client's every three hour cleansing/protective cream, although only one staff member initialed the

document as having read it. The client's care plan, which the direct care staff utilized, was not updated to reflect every three hour and as needed changing of the client's incontinent brief and encouraging the client to position off her bottom and walk every shift until twelve days later.

On the outside home care agency nurse's visits to the client, the nurse noted on her visits, that the client's brief was soaked with urine and no barrier cream was noted to be on the client's buttocks as ordered.

The nurse practitioner saw the client's wound again a week later and noted the client's had again increased in size from the previous week. The client's wound care treatment was changed to three times a week and whenever necessary; cleansing the wound, applying a product to the wound bed and covering the wound with a dressing.

The outside home care agency completed the three times a week dressing changes and the facility was to replace the client's dressing as needed. Four days after the new wound care treatment was ordered, the home care nurse came to the facility to change the client's dressing and noted the client's incontinent brief was fully soaked and no dressing was covering the wound. In addition, on another home care visit, the home care nurse noted the incorrect application of the wound care product.

The nurse practitioner saw the client's wound again, a week later and noted the client did not have a dressing covering the wound, and the client's incontinence pad/brief was saturated with urine. Redness was noted on the client's buttocks due to the chemical irritant of urine, the client's ulcer has worsened and a new ulcer was noted on the client's left buttock. The note indicated ideally the client should be transferred to another facility to assist with adequate wound care adherence. The client's wound treatment was changed to use a different product on the wound bed.

Approximately twenty-three days after the client was admitted to the facility, the client was transferred to hospital #1 due to an increased temperature and warmth and hardness around the ulcer. No changes were made and the client was discharged back to the facility.

Two days later, the client had a temperature, complained of chills and verbalized pain in the left buttock area. The client was transferred to hospital #2 where the client was admitted to the hospital with an abscess of her left buttock which required surgical incision and drainage. An extensive area of dead tissue and abscess was discovered. The wound was debrided and the nonviable tissue was removed. The final wound size after surgery was 15 centimeters by 15 centimeters. The client was discharged to a long term acute care hospital for further care and treatment.

The nurse practitioner stated staff were vague as to what treatment they were providing for the client's wound the first week the client was admitted. The nurse practitioner stated she changed the client's wound treatment order after that to include frequent incontinent pad changes and when she saw the client a week later, the wound had increased in size and there was nonviable tissue present which was a change. The nurse practitioner stated she saw the client a week later and the client's incontinent brief/pad was wet and there was no dressing on the wound when there should have been a dressing. The nurse practitioner stated in her medical opinion the client's wound got worse because of the lack of care from the facility. The nurse practitioner stated staff at the facility were not on top of the client's wound treatments as they should have been.

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 of health care. Although the facility had policies/procedures to relay care related information to the direct care staff providing care to the client, those policies/procedures were not implemented on a consistent basis. The client's assignment sheet was not updated to reflect the client had an open area on her buttocks, nor did it reflect the current treatments for the client's open area. The client's care plan was not updated to reflect the client's current treatment to the open area. A "Daily Log" used to communicate changes to staff regarding the client's wound treatment change was only reviewed by one direct care staff.

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

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

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

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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.

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.

The Investigation included the following:

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

☒ Medical Records	☐ Care Guide
☒ Medication Administration Records	☒ Treatment Sheets
☐ Facility Incident Reports	☒ Physician Progress Notes
☒ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☐ Social Service Notes
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records
☐ Therapy and/or Ancillary Services Records	☒ Assessments
☒ Skin Assessments	☒ Care Plan Records
☐ Service Plan	☐ Other, specify: _____

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report ☒ Other, specify: Home Care Records

Additional facility records:

☐ Resident/Family Council Minutes ☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

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 hospitalized.

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 hospitalized.

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: 0-The client resided on a memory care unit. Clients were visited but were unable to be interviewed.

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 7

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ◉ Yes ○ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator was identified.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

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

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☒ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Home Care & Assisted Living Program
St. Paul City Police Department
Ramsey County Attorney
St. Paul City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H29564	A. BUILDING: _____ B. WING _____	C 03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE HIGHLAND PARK	750 MISSISSIPPI BOULEVARD SAINT PAUL, MN 55116

(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
0 000	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 October 14, 2015, a complaint investigation was initiated to investigate case #HL29564001. At the time of the survey, there were 62 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/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 265	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	0 265		

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0 265	Continued From page 1 accepted health care, medical or nursing 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 failed to ensure care was provided according to the plan of care for one of three clients (C1) reviewed who were treated for skin conditions. This practice resulted in a level 4 violation (a violation that results in serious injury, impairment, or death) and is issued at an isolated scope (1 or a limited number of clients are affected). The findings included: C1's record was reviewed. C1 was admitted to the facility on September 9, 2015. C1's nursing assessment dated September 3, 2015 and reviewed on September 14, 2015 indicated the client was admitted to the facility with a sacral ulcer that measured 2 by 1 centimeter, was incontinent of urine and required physical assist of one with toileting 4-7 times a day and required stand-by assist with ambulation. Admission physician's orders dated August 31, 2015 indicated the wound care was as follows: Cleanse wound daily using Hibiclens (30cc Hibiclens/500 cc normal saline, Rinse with saline, Pat dry, Apply Santyl nickel thickness to wound base (a debriding agent). Apply Cavilon barrier spray (or like skin protectant to skin around wound, cover with Mepilex (a foam dressing) one time daily. Admission orders also indicated that a outside home care agency was involved in treating the ulcer.	0 265		

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0 265	Continued From page 2 C1's Medication Administration Record for September 2015 indicated the treatment to C1's sacral ulcer, but noted it was a "FYI" (for your information) and that an outside service does the treatment. A review of the outside home care agency notes indicated that on September 10, 2015, an initial assessment of C1's wound was done and visits were set up to change C1's wound three times a week. The outside home care agency completed C1's wound care on September 10, 2015 and September 14, 2015. There was no evidence the licensee coordinated the treatment of C1's wound with the outside home care agency to ensure that the treatment was done on a daily basis. There was no evidence that the licensee completed C1's wound treatment from admission, September 9, 2015 to September 16, 2015. C1's care plan dated September 9, 2015 indicated the client had an open area to left of the midline. Special instructions were to notify supervisor if the client had any of the following changes in condition: discoloration, swelling, bruises, increased pain, decreased mobility, decreased appetite, new wound, and bleeding. C1's care plan indicated the client was to be assisted with mobility, and transfers and to encourage activities, but there was no direction to staff assist/remind the client to keep off the open area to relieve pressure to the area. The September 9, 2015 assignment sheet that the direct care staff used to know what care they need to provide for the clients was reviewed. The assignment sheet indicated that C1 was independent in bed mobility and transferring and	0 265		

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0 265	Continued From page 3 was standby assist with walker and uses a wheelchair in her room. Under toileting, the assignment sheet indicated the client was one assist with toileting before/after meals/activities, frequent checks per shift approximately 4-7 times daily. Under skin care, the assignment sheet indicated staff were to watch for redness and report to nursing right away. The assignment sheet did not indicate that the client had a ulcer on her sacral area. A nurse practitioner's note dated September 16, 2015, indicated C1's sacral ulcer had increased in size since admission (September 9, 2015) to 5 centimeters by 2.5 centimeters by 1 centimeter, 15 % slough and was macerated with stool and urine and no dressing was in place. The nurse practitioner order dated September 16, 2015 indicated to discontinue the current wound care to the ulcer and start every three hours (not overnight hours) cleansing the area if soiled with stool/urine) with wound cleanser, pat dry, Apply Calazime cream (skin protectant) or insurance equivalent. The order also indicated C1 needed assistance with the changing of her incontinence product every three hours if soiled as well. The nurse practitioner also ordered a seat cushion to be ordered due to the buttock ulcer. There was no evidence in C1's record that the September 16, 2015 every three hour cleansing the open area and applying Calazime cream was implemented on a consistent basis by the licensee. A "Daily Log" document dated September 16, 2015 at 4:20 p.m. indicated the following for C1, "Wound care: RA's (resident assistant), Please follow these instructions for (C1's name): Every 2-3 hours cleanse wound area (if soiled with	0 265		

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0 265	Continued From page 4	0 265		

stool/urine) with wound cleanser. Pat dry. Apply calamizine cream. Also change incontinent product every 3 hours if soiled as well." (sic) On the bottom of the document there was an area for the team members to initial when they have read this document. The document had only one staff initial on it.

C1's care plan was not updated until September 28, 2015 with special instructions for staff to encourage toileting, change resident every three hours and as needed and encourage resident to get off her bottom and walk every shift.

The outside home care agency's visit notes for C1 were reviewed. On September 18, 2015 registered nurse (RN)-G from the outside home care agency made a visit. The client was at breakfast when the nurse arrived. When C1 came back to her room, RN-G noted C1's brief was soaked and no barrier cream was noted to be on C1's buttocks as ordered. On September 21, 2015 RN-G's visit note indicated C1's brief was fully soaked and there was no evidence of cream being placed. RN-G recommended written tracking sheet for staff completing wound care. On the September 23, 2015 visit, RN-G noted C1's brief was fully soaked and there was no evidence of the barrier cream being applied. RN-G discussed again with staff about tracking wound cares.

A nurse practitioner's note dated September 23, 2015 indicated C1's coccyx ulcer was now unstageable and had increased in size from last week (September 16, 2015) with nonviable tissue present. The nurse practitioner's noted indicated she discussed concerns with facility staff and the note indicated that facility staff would attempt to improve cares for the client. The nurse

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0 265	Continued From page 5 practitioner changed the wound care treatment to Cleanse the area with wound spray, Pat dry, Skin prep to wound. Calcium alginate to wound bed. Cover with hydrocolloid dressing and to change three times a week and whenever necessary. The new treatment was to start on September 25, 2015. The nurse practitioner's note also indicated that C1 needed continued assistance with incontinence products as the client was unable to feel that she was wet due to a neuropathic component due to her previous surgical history. The outside home care agency's visit note for September 28, 2015 indicated RN-G spoke with the facility on September 25, 2015 and the nurse at the facility stated they would replace C1's dressing if it falls off. When RN-G arrived today, the nurse found C1's brief fully soaked and no dressing covering the wound. A nurse practitioner's visit note dated September 29, 2015 indicated the following, C1's sacral ulcer was found without a dressing on. There was brown/yellow drainage on the incontinence brief and the client's incontinence pad was wet/saturated. Redness was also noted on the client's buttocks due to chemical irritant of urine. Redness and maceration noted to be surrounding the ulcer as well as a new ulcer was found on the client's left buttock from the five o'clock position of old ulceration. The ulcer was covered with gray nonviable tissue. The note indicated that the client needed improvement in perineal care and barrier cream application. The note also indicated that ideally the client should be transferred to another facility to assist with adequate wound care adherence. C1's wound treatment was changed to use Aquacel Ag on the wound bed instead of calcium alginate. Blood tests were also ordered due to C1's worsening wound.	0 265		

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0 265	Continued From page 6 The outside home care agency's visit note for September 30, 2015 indicated RN-G noted that the Aquacel Ag was not on the wound bed, but was rather attached to the dressing. RN-G educated the nurse at the facility on the wound care procedure. A progress note dated October 2, 2015 indicated C1's left buttock and around the sacral ulcer, was warm to touch and hardened. C1 had a temperature of 100.2 degrees Fahrenheit. C1 was sent to hospital #1 for evaluation. Hospital #1's records for C1 were reviewed and indicated the following: "Ulcer did not appear to have signs of infection including significant erythema or weeping discharge." C1 was discharged back to the facility. A progress note dated October 4, 215 indicated the client had a temperature of 100.6 degrees Fahrenheit and was having chills and verbalized pain in left buttock area. C1 was transferred to hospital #2. Hospital #2's records for C1 were reviewed and indicated the following: C1 was admitted to the hospital with an Abscess of her left buttock which required surgery. C1's sacral ulcer was incised and drained. . An extensive area of tissue necrosis and abscess was discovered. The wound was debrided and the nonviable tissue removed. The final wound size after surgery was 15 centimeters by 15 centimeters. The client remained in the hospital for treatment of the wound for nine days and was discharged to a long term acute care hospital for further care and treatment.	0 265		

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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
0 265	Continued From page 7 When interviewed October 14, 2015 at 2:15 p.m., unlicensed person (ULP)-D stated on her shift, she would toilet C1 twice. ULP-D stated one time at the beginning of the shift and then again before the evening meal. ULP-D stated sometimes when C1 was wet from incontinence of urine, the dressing would come off, or the client would take the dressing off herself. ULP-D stated C1's wound was not getting better and she would report it to the nurse. When interviewed January 21, 2016 at 9:06 a.m., licensed practical nurse (LPN)-I stated when C1 was first admitted, an outside home care agency was to follow C1 and do her wound care. LPN-I stated staff were to look at C1's wound and if something was wrong staff would let the outside home care agency know. LPN-I stated on September 16, 2015, the nurse practitioner changed the order for C1's wound care. LPN-I stated she put the information regarding C1's wound care treatment for the direct care staff to follow on a "Daily Log" for the staff to read and initial the document that they have read it. When questioned regarding updating the direct care staff assignment sheet, LPN-I stated she would notify the coordinator to update the assignment sheet. LPN-I stated she was not sure she updated the coordinator to update the assignment sheet for C1 in this case, stating if it was a temporary change, the assignment sheet may not get updated, staff would use the "Daily Log" to communicate the change. When interviewed January 19, 2016 at 2:45 p.m., registered nurse (RN)-H stated when C1 was first admitted an outside home care agency was to provide daily dressing changes. RN-H stated the facility did not have Santyl in the building to put on the wound. RN-H stated she did not have	0 265		

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	H29564	A. BUILDING: _____ B. WING _____	C 03/31/2016

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0 265	Continued From page 8 a conversation with the home care nurse until September 15, 2015 (six days after admission to the facility.) RN-H stated staff were watching C1's wound and putting Duoderm (a hydrocolloid dressing) on the wound when necessary. When interviewed January 19, 2016 at 11:05 a.m., RN-A stated when the direct care staff completed personal cares for a client they initial on a activities of daily living sheet for their shift, that they have completed care according to the client's care plan and assignment sheets. RN-A verified the activities of daily living sheet for C1 was not able to be found for the month of September and October of 2015. When asked to see the direct care staff's assignment sheets and any updates to C1's assignment sheet, RN-A stated the only assignment sheet for C1 that she could find was the one that was developed when C1 was admitted on September 9, 2015. RN-A stated that if the assignment sheet was updated, whatever was changed on the assignment sheet would no longer exist. RN-A confirmed that C1's care plan was not updated with the September 16 and 23, 2015 wound treatment changes until September 28, 2015. When interviewed January 21, 2016 at 3:00 p.m., the nurse practitioner stated she saw C1 on September 16, 2015 and C1 did not have a dressing on her wound. The nurse practitioner stated when staff were questioned, they were vague as to what the facility was doing for wound treatment, but stated they were under the understanding that the outside home care agency was doing daily dressing changes, when they were only doing three times a week dressing changes. The nurse practitioner stated she changed the treatment order to include frequent incontinent pad changes and when she saw the	0 265		

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0 265	Continued From page 9 client a week later, the wound had increased in size and there was nonviable tissue present which was a change. The nurse practitioner stated she saw C1 again on September 29, 2015 and the client's incontinent brief/pad was wet and there was no dressing on the wound when there should have been a dressing. The nurse practitioner stated that in her medical opinion C1's wound got worse because of the lack of care from the facility. The nurse practitioner stated staff at the facility were not on top of C1's wound as they should have been. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 265		
0 325	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 ensure that clients were free from neglect of health care for one of three clients (C1) who were treated for skin conditions. This practice resulted in a level 4 violation, (a violation that results in serious injury, impairment, or death) and is issued at an isolated scope (1 or a limited number of clients are affected). The findings included: C1's record was reviewed. C1 was admitted to	0 325		

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0 325	Continued From page 10 the facility on September 9, 2015. C1's nursing assessment dated September 3, 2015 and reviewed on September 14, 2015 indicated the client was admitted to the facility with a sacral ulcer that measured 2 centimeters by 1 centimeter, was incontinent of urine and required physical assist of one with toileting 4-7 times a day and required stand-by assist with ambulation. There was no evidence that C1's admission orders dated August 31, 2015 for her daily wound treatment were being completed as ordered. C1's Medication Administration Record for September 2015 indicated the treatment to C1's sacral ulcer, but indicated it was a FYI (for your information) and that an outside service does the treatment. A review of the outside home care agency noted dated September 2015 indicated the outside home care agency was completing C1's wound care treatment only three times a week. There was no evidence the licensee coordinated the treatment of C1's wound with the outside home care agency to ensure that the treatment was done on a daily basis. There was no evidence that the licensee completed C1's wound treatment from admission, September 9, 2015 to September 16, 2015. C1's care plan dated September 9, 2015 indicated the client had an open area to left of the midline. C1's care plan indicated the client was to be assisted with mobility, and transfers and to encourage activities, but there was no direction to staff assist/remind the client to keep off the open area to relieve pressure to the area. C1's assignment sheet dated September 9, 2015	0 325		

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0 325	Continued From page 11 under skin care, indicated staff were to watch for redness and report to nursing right away. The assignment sheet did not indicate that the client had a ulcer on her sacral area. A nurse practitioner's visit note dated September 16, 2015, indicated C1's sacral ulcer had increased in size since admission (September 9, 2015) to 5 centimeters by 2.5 centimeters by 1 centimeter, 15 % slough and was macerated with stool and urine and no dressing was in place. The nurse practitioner changed C1's wound treatment to every three hours (not overnight hours) cleansing the area if soiled with stool/urine) with wound cleanser, pat dry, Apply Calazime cream (skin protectant) or insurance equivalent. The order also indicated C1 needed assistance with the changing of her incontinence product every three hours if soiled as well. The nurse practitioner also ordered a seat cushion to be ordered due to the buttock ulcer. There was no evidence that C1's September 16, 2015 prescriber's order to cleanse the open area every three hours and apply Calazime cream was implemented on a consistent basis by the licensee. The September 16, 2015 wound care treatment was listed on a "Daily Log" document which staff used to communicate changes with clients, although only one direct care staff initialed the log that they had read the instructions. C1's care plan was not updated until September 28, 2015 with special instructions for staff to encourage toileting, change resident every three hours and as needed and encourage resident to get off her bottom and walk every shift.	0 325		

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0 325	Continued From page 12 The outside home care agency's visit notes for C1 by registered nurse (RN)-G were reviewed and indicated on September 18, 21 and 23, 2015, C1's incontinent brief was noted to be soaked with urine and no barrier cream was noted on C1's buttocks as ordered. On two of these visits RN-G recommended/discussed with staff developing a tracking sheet for staff completing wound care. A nurse practitioner's note dated September 23, 2015 indicated C1's coccyx ulcer was now unstageable and had increased in size from last week (September 16, 2015) with nonviable tissue present. The nurse practitioner's noted indicated she discussed concerns with facility staff and the note indicated that facility staff would attempt to improve cares for the client. The nurse practitioner changed the wound care treatment to Cleanse the area with wound spray, Pat dry, Skin prep to wound. Calcium alginate to wound bed. Cover with hydrocolloid dressing and to change three times a week and whenever necessary. The new treatment was to start on September 25, 2015. The nurse practitioner's note also indicated that C1 needed continued assistance with incontinence products as the client was unable to feel that she was wet due to a neuropathic component due to her previous surgical history. The outside home care agency's visit note dated September 28, 2015 indicated RN-G spoke with the facility on September 25, 2015 and it was agreed upon that the outside home care agency would complete the three times a week dressing changes and the nurse at the facility would replace C1's dressing if it fell off in between times. When RN-G arrived September 28, 2015, the home care nurse found C1's brief fully soaked and no dressing covering C1's wound.	0 325		

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0 325	Continued From page 13 A nurse practitioner's visit note dated September 29, 2015 indicated the following, C1's sacral ulcer was found without a dressing on. There was brown/yellow drainage on the incontinence brief and the client's incontinence pad was wet/saturated. Redness was also noted on the client's buttocks due to chemical irritant of urine. Redness and maceration noted to be surrounding the ulcer as well as a new ulcer was found on the client's left buttock from the five o'clock position of old ulceration. The ulcer was covered with gray nonviable tissue. The note indicated that the client needed improvement in perineal care and barrier cream application. The note also indicated that ideally the client should be transferred to another facility to assist with adequate wound care adherence. C1's wound treatment was changed to use Aquacel Ag on the wound bed instead of calcium alginate. Blood tests were also ordered due to C1's worsening wound. The outside home care agency's visit note for September 30, 2015 indicated RN-G noted that the Aquacel Ag was not on the wound bed, but was rather attached to the dressing. RN-G educated the nurse at the facility on the wound care procedure. A facility nurse progress note dated October 2, 2015 indicated C1's left buttock and around the sacral ulcer, was warm to touch and hardened. C1 had a temperature of 100.2 degrees Fahrenheit. C1 was sent to hospital #1 for evaluation. Hospital #1's records for C1 were reviewed and indicated the following: "Ulcer did not appear to have signs of infection including significant erythema or weeping discharge." C1 was	0 325		

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0 325	Continued From page 14 discharged back to the facility. A progress note dated October 4, 2015 indicated the client had a temperature of 100.6 degrees Fahrenheit, was having chills and verbalized pain in her left buttock area. C1 was transferred to hospital #2. Hospital #2's records for C1 were reviewed and indicated the following: C1 was admitted to the hospital with an abscess of her left buttock which required surgery. C1's sacral ulcer was incised and drained. An extensive area of tissue necrosis and abscess was discovered. The wound was debrided and the nonviable tissue removed. The final wound size after surgery was 15 centimeters by 15 centimeters. The client remained in the hospital for treatment of the wound for nine days and was discharged to a long term acute care hospital for further care and treatment. When interviewed October 14, 2015 at 2:15 p.m., unlicensed person (ULP)-D stated on her shift, she would toilet C1 twice on her shift. ULP-D stated one time at the beginning of the shift and then again before the evening meal. ULP-D stated sometimes when C1 was wet from incontinence of urine, the dressing would come off, or the client would take the dressing off herself. ULP-D stated C1's wound was not getting better and she would report it to the nurse. When interviewed January 21, 2016 at 9:06 a.m., licensed practical nurse (LPN)-I stated when C1 was first admitted, an outside home care agency was to follow C1 and do C1's wound care. LPN-I stated staff were to look at C1's wound and if something was wrong staff would let the outside home care agency know. LPN-I stated on	0 325		

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0 325	Continued From page 15 September 16, 2015, the nurse practitioner changed the order for C1's wound care. LPN-I stated she put the information regarding C1's wound care treatment for the direct care staff to follow on a "Daily Log" for the staff to read and initial the document that they have read it. LPN-I also stated she reviewed the wound treatment with staff who came on duty during shift report. When questioned regarding updating the direct care staff assignment sheet, LPN-I stated she would notify the coordinator to update the assignment sheet. LPN-I stated she was not sure she updated the coordinator to update the assignment sheet in this case, stating if it was a temporary change, the assignment sheet may not get updated, staff would use the "Daily Log" to communicate the change. When interviewed January 19, 2016 at 2:45 p.m., registered nurse (RN)-H stated when C1 was first admitted an outside home care agency was to provide daily dressing changes. RN-H stated the facility did not have Santyl in the building to put on the wound which was initially ordered. RN-H stated she did not have a conversation with the home care nurse until September 15, 2015 (six days after admission to the facility.) RN-H stated staff were watching C1's wound and putting Duoderm (a hydrocolloid dressing) on the wound when necessary. When interviewed January 19, 2016 at 11:05 a.m., RN-A stated when the direct care staff completed personal cares for a client they initial on a activities of daily living sheet for their shift, that they have completed care according to the client's care plan and assignment sheets. RN-A verified the activities of daily living sheet for C1 was not able to be found for the month of September and October of 2015. When asked to	0 325		

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0 325	Continued From page 16 see the direct care staff's assignment sheets and any updates to C1's assignment sheet, RN-A stated the only assignment sheet for C1 that she could find was the one that was developed when C1 was admitted on September 9, 2015. RN-A stated that if the assignment sheet was updated, whatever was changed on the assignment sheet would no longer exist. RN-A confirmed that C1's care plan was not updated with the September 16 and 23, 2015 wound treatment changes until September 28, 2015. When interviewed January 21, 2016 at 3:00 p.m., nurse practitioner stated she saw C1 on September 16, 2015 and C1 did not have a dressing on her wound. The nurse practitioner stated when staff were questioned, they were vague as to what staff were doing for wound treatment, but stated they were under the understanding that the outside home care agency was doing daily dressing changes, when they were really doing three times a week dressing changes. The nurse practitioner stated she changed the treatment order to include frequent incontinent pad changes and when she saw the client a week later, the wound had increased in size and there was nonviable tissue present which was also a change. The nurse practitioner stated she saw C1 again on September 29, 2015 and the client's incontinent brief/pad was wet and there was no dressing on the wound when there should have been a dressing. The nurse practitioner stated that in her medical opinion C1's wound got worse because of the facility's lack of care. The nurse practitioner stated staff at the facility were not on top of C1's wound as they should have been. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
H29564	A. Building B. Wing	6/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 00265 Reg. # 144A.44, Subd. 1(2) LSC	Correction Completed 06/02/2016	ID Prefix 00325 Reg. # 144A.44, Subd. 1(14) LSC	Correction Completed 06/02/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/31/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: Y5Q012

STATE FORM: REVISIT REPORT (11/06)