DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL31955049M
Compliance #: HL31955050C

Date Concluded: July 27, 2021

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living LLC
820 Lilac Drive, North; Suite 170
Golden Valley, MN 55422
Hennepin County

Name, Address, and County of Housing with Services location:
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN 55427
Hennepin County

Facility Type: Home Care Provider

Investigator's Name:
Michele R. Larson, RN Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The facility neglected the client when staff failed to assess and report a change in the client's condition when the client developed gangrene in his right foot. The client was sent to the hospital and underwent surgery for amputation of his right foot. As a result of the gangrene, the client eventually had a below the knee amputation (BKA).

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected the client when staff failed to monitor the client's skin and provide daily scheduled foot checks until he had blackened toes. The client developed gangrene on his right foot, which required amputation.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, unlicensed staff, family members, and the client. The investigation included

review of the client's medical record, including hospital and clinic records, facility policies, procedures, incident reports, and facility's internal investigation.
The client's medical diagnoses included Type 2 Diabetes, End Stage Renal Disease (ESRD), diabetic neuropathy, diabetic retinopathy in both eyes, chronic kidney disease (CKD), difficulty in walking, and legal blindness in both eyes. The client received comprehensive home care services for medication management, personal cares including twice weekly bathing assistance, dressing assistance, daily foot checks, assistance with transfers, meals, and housekeeping. The client was alert and oriented and able to make his needs known but had documented legal blindness in both eyes. The client lived on the second floor of the facility. The client's medical record indicated he used a wheelchair and walker for mobility, but later used only a wheelchair due to increased weakness.

One morning when getting the client dressed for a scheduled doctor's appointment, an unlicensed staff person discovered the client's right big toe, and second toe were black. The client was unable to state why he had black toes and told the unlicensed staff person he could not see very well. The client reported no pain. The facility's nursing and administrative staff were notified. Soon after the client went to his scheduled appointment using his regular medical transport service. When he arrived at his clinic, he was met by a family member. The client told his family member the facility instructed him to tell his doctor to look at his right foot. After the doctor assessed his right foot, the client was admitted to a local hospital with a diagnosis of gangrene of the right foot. A few days later the client underwent amputation of his right foot.

The facility's incident report was reviewed. The report indicated an unlicensed staff person saw the client's right toes were black. The client was unable to state how his toes became black and said he could not see very well. The report indicated nursing staff were notified. No vital signs were taken. A preventative plan included keeping the client's apartment free of clutter, checking both feet for skin concerns due to the client's minimal vision, and ensuring the client's legs did not hit against the wheelchair to prevent injuries.

The facility's investigation report was reviewed. The investigation included interviews with unlicensed staff who performed cares for the client. The report indicated three days before the client went to his doctor's appointment, an unlicensed staff person noticed the client's right big toe and second toes were black during a dressing change. The unlicensed staff person said when he removed the client's socks, he noticed the client's skin on the top of his right foot was black near his big right toe. The unlicensed staff person said he thought the client's black toes were a normal symptom of diabetes. The unlicensed staff person said he never saw the client's feet since he always wore socks.

Review of the client's clinic medical records indicated the client arrived at the medical clinic for a previously scheduled doctor's appointment for left shoulder pain. A family member met the client at the clinic. The clinic medical records indicated the facility sent a note with the client indicating to have his doctor look at his right big toe. The client stated he never noticed any

discoloration on his right foot, and said he never paid attention to his feet. The client told his doctor his toes were to be examined daily by a nurse but said no one looked at his feet for weeks. A podiatrist was called in to examine the client's right foot. The client was diagnosed with dry gangrene of the right foot and was admitted to a local hospital.

Review of the client's hospital records indicated the client was unsure how long his right toes were black and was unsure the last time his feet were checked, even though he had scheduled daily foot checks. The hospital record indicated the client had extensive gangrenous changes in his right big and second toes. A few days later the client underwent partial amputation of his right foot.

Review of the client's facility medical record indicated the client's doctor prescribed orders to have the nurse report to them, the client's blood sugars below 60 mg/dL and above 300 mg/dL. Unlicensed staff were to report immediately to a nurse when the client had those out-of-range values. The client's medical record indicated during a three-month period; the client had 27 blood sugars readings above 300 mg/dL. Of those values, eight of his blood sugars were above 400 mg/dL. No documentation was provided indicating the out-of-range blood sugars were immediately reported to his doctor.

During an interview, unlicensed staff person said she discovered the client's black toes while performing the client's morning cares. The unlicensed staff person said she was getting the client ready for his doctor's appointment. The unlicensed staff person said she noticed his entire toes were black up to the top of his right foot. The unlicensed staff person said it alarmed her to see his toes black and asked the client if he saw his toes. The unlicensed staff person felt his right foot and asked the client if he felt her touching his right foot. The client stated he could not feel the warmth or touch of her hand on his right foot. The unlicensed staff person summoned the nurse manager to assess the client. The unlicensed staff person said when you looked at the client's right foot you could tell his foot checks were not getting done.

During an interview, the nursing manager said an unlicensed staff person who worked in the office was responsible for ensuring unlicensed staff performed client services. The nursing manager said the unlicensed staff person checked client services weekly but only checked service that were marked not completed or partially done. The nurse manager said she was notified weekly if service were not being completed. The nursing manager said she was notified that morning by the unlicensed staff person who discovered the client's black toes. The nursing manager said the client was about to leave for his medical appointment but had already left. The nursing manager was unsure if she called the clinic to let them know about his right foot. The nurse manager said at the clinic, they looked at the client's right foot. The nurse manager said she did not recall having further conversations with his doctors or any follow-ups regarding his condition. The nurse manager said she started an investigation immediately after finding out about the client's right toes. The nurse manager said it was a red flag and it was never okay for the client to not have showers. The nurse manager said the client was supposed to have his socks changed daily.

During an interview, the client's family member said she found out about the client's right foot a few hours later when the client was at his doctor's appointment. The family member said the client always used a local medical transport service to take him to and from his appointments, where the family member would meet the client. The family member said the morning his right toes were found black, the client used the same service to bring him to his scheduled appointment. The family member said she had care conferences with the facility regarding the client's cares. The family member said the client would tell her when he did not get his showers.

During an interview, another client family member said the client was told two days earlier by an unlicensed staff person his right foot was black. The family member said the facility never contacted him or other family members about the client's condition.

Review of mayoclinic.org website, indicated dry gangrene involved skin that looked brown, to purplish blue or black. The website indicated dry gangrene developed slowly and occurred in people who had diabetes. Prevention included checking feet daily for cuts, sores, and signs of infection such as redness, swelling, or drainage.

In conclusion, 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:
(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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes. Two family members were interviewed.
Alleged Perpetrator interviewed: Not applicable.
Action taken by facility:

The facility verbally re-educated unlicensed staff on reporting clients change in conditions.

Action taken by the Minnesota Department of Health:
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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc: The Office of Ombudsman for Long-Term Care
Hennepin County Attorney
Golden Valley City Attorney
Golden Valley Police Department
The Minnesota Board Of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H31955	A. BUILDING: _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING	3030 SOUTH LAWN DRIVE MAPLEWOOD, MN 55109

(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, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On May 11, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL31955050C/#HL31955049M. At the time of the survey, there were 98 clients receiving services under the comprehensive license. The following correction orders are issued for #HL31955050C/#HL31955049M, tag identification 325, 805, 865, 1045, 2015.	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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) 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 observations, interviews, and document review, the facility failed to ensure one of four clients (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On July 27, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No plan of correction is required for tag 325. Please refer to public maltreatment report for details.	
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that	0 805		

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0 805	Continued From page 2 all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of four clients (C1) reviewed. C1 had out-of-range uncontrolled blood sugars that were not reported in a timely manner to C1's physician. C1 developed gangrene on his right foot, was hospitalized, and later had amputation of his right lower extremity. 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). Findings include: C1's medical record was reviewed. C1's diagnoses included, but were not limited to, End Stage Renal Disease (ESRD), diabetic neuropathy, bilateral diabetic retinopathy, type 2 diabetes mellitus with chronic kidney disease (CKD), peripheral vascular disease (PVD), difficulty in walking, and bilateral legal blindness. C1's medical record indicated C1 used a walker and wheelchair for mobility. C1's Individual Abuse Prevention Plan dated March 26, 2020, indicated C1 was at risk for being abused. C1 was assessed as legally blind	0 805		

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0 805	Continued From page 3 and required assistance with his activities of daily living (ADL)'s. C1's mobility was impaired due to previous left toes amputation, vision impairment, and history of falls. Licensee staff were to monitor for any signs of neglect from others and report to the registered nurse (RN) promptly for any changes in condition. Review of C1's physician orders indicated on June 19, 2020, C1's physician ordered twice daily blood glucose checks and notification from a licensee nurse whenever C1's blood glucose readings fell below 60 mg/dL or above 300 mg/dL, in addition to weekly faxed blood glucose results. Review of C1's blood glucose readings dated October 1, 2020 though December 22, 2020, indicated C1 had 25 blood glucose readings above 300 milligrams per deciliter (mg/dL). Review of C1's medical record provided by the licensee for C1 did not include documentation C1's physician was notified regarding C1's out-of-range blood glucose levels. C1's progress note dated November 19, 2020, at 9:01 a.m., indicated C1's physician sent a faxed communication to RN-E requesting RN-E contact C1's family to schedule a telehealth visit related to C1's elevated blood sugars. The progress note indicated RN-E left a voice message for C1's family member. A review of C1's progress notes provided by the licensee did not include documentation a telehealth visit was scheduled. C1's service plan, dated December 1, 2020, indicated C1 received assistance with personal	0 805		

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0 805	Continued From page 4 cares, medication management, transfer assist of one, housekeeping, daily safety checks, twice daily blood glucose checks, and three times weekly dialysis treatments. C1 used a wheelchair and walker for mobility. C1's service plan indicated unlicensed personnel (ULP) were to notify a immediately for any blood glucose readings below 70 or above 300 milligrams per deciliter (mg/dL). C1's blood glucose results were to be faxed weekly to C1's physician. C1's service plan indicated ULP were to inspect C1's feet daily when changing C1's socks, and twice weekly during bathing assistance on Tuesdays and Saturdays. Inspection of C1's feet included inspecting both feet (top and bottom) for open areas, changes in color, swelling, or any area of concern. Changes in C1's feet were to be reported immediately to a nurse. ULP staff were to update a nurse immediately if C1 refused to change his socks. C1's incident report dated December 22, 2020, at 9:25 a.m., and completed by RN-E, indicated ULP-C was getting C1 dressed for a scheduled doctor's appointment at 12:00 p.m., when she noticed necrosis on C1's right big and second toes. ULP-C notified RN-E, who alerted C1's physician to assess C1's right foot during his scheduled appointment. The incident report indicated after being seen by his physician, C1 was admitted to a local hospital with a diagnosis of gangrene of the right foot. Review of the licensee internal investigation conducted on December 22, 2020, indicated ULP's who performed cares for C were interviewed regarding C1's cares, including feet inspection. ULP-I said she did not see any black toes on C1's feet. ULP-F said while working the evening shift on December 19, 2021, he noticed	0 805		

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0 805	Continued From page 5 C1's right big toe was black at the top when he changed C1's socks, but said he did not report it to a nurse since he thought it was normal for clients with diabetes. ULP-F said C1 always wore socks so he was not able to check his feet. Review of C1's clinic medical record dated December 22, 2020, indicated C1's physician received a note from the licensee, requesting C1's physician assess C1's right big toe during his scheduled clinic appointment at 12:00 p.m. that day. The progress note indicated C1's physician noticed C1 had developed gangrene on his right big toe and second toe. The progress note indicated C1's toes were completely black in color. C1's right extremity was cold with absent distal pulses, along with redness and swelling on top of his foot. The progress note indicated C1 said he never noticed discoloration on his right foot and denied being in pain. C1 said he never paid attention to his feet. C1 told his physician his feet were to be examined daily, but said his feet were not checked for weeks. During an interview on May 11, 2021, at 11:00 a.m., ULP-C said C1 was "with it", but he could not see, stating, "he could hardly see anything in front of him." During an interview on May 13, 2021, at 1:33 p.m., RN-E said communications with C1's physician, including out-of-range blood sugars, were documented in progress notes. The licensee policy titled, Maltreatment of a Vulnerable Adult-Communication, Prevention, and Reporting, dated March 29, 2019, indicated licensed staff would report any from of suspected neglect or abuse to the RN or Executive Director (ED), or call MAARC directly. The licensee RN or	0 805		

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0 805	Continued From page 6 ED would immediately make an oral or written report to MAARC. Immediately meant as soon as possible and no longer than 24 hours. TIME PERIOD TO CORRECT: Seven (7) days.	0 805		
0 865 SS=J	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan.	0 865		

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0 865	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to implement and ensure all services were provided for 1 of 4 clients (C1) reviewed. The licensee also and implemented as directed in the service plan for C1. Staff failed to provide showers and daily feet checks due to a risk of skin breakdown related to C1's diagnoses. C1 developed gangrene and required amputation of his foot. 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's diagnoses included, but were not limited to, End Stage Renal Disease (ESRD), diabetic neuropathy, bilateral diabetic retinopathy, type 2 diabetes mellitus with chronic kidney disease (CKD), peripheral vascular disease (PVD), difficulty in walking, and bilateral legal blindness. C1's medical record indicated C1 used a walker and wheelchair for mobility. C1's medical record indicated C1 was ordered a liberal renal diet, no added salt (NAS), thin liquids, regular texture, low fat, and low cholesterol diet. C1's service plan, dated December 1, 2020, indicated C1 received assistance with personal cares, medication management, meals, transfer assist of one, housekeeping, daily safety checks, glucose checks, and daily inspection of feet.	0 865		

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0 865	Continued From page 8 Unlicensed personnel (ULP) were to assist C1 daily, and as needed, in sitting up in bed and assisting C1's transfers from his bed to his wheelchair using a gait belt. To prevent skin injuries, ULP were to ensure C1's limbs did not hit against his wheelchair during transfers. In addition, C1's service plan indicated he received assistance with meal-set up every morning at 7:05 a.m., due to being legally blind. Any changes in condition with C1's feet or refusing to have his feet inspected were to be reported to a nurse immediately. C1's 90 day assessment dated, December 9, 2020, and completed and electronically signed by registered nurse (RN)-E, indicated C1 was assessed as requiring assistance with dressing, grooming, bathing, bed mobility, and toileting. C1 was assessed as independent in managing own diet, drinking regular liquids, and set-up assist with eating due to impaired vision. C1 was assessed as needed assistance of one with transfers and used a wheelchair for mobility. C1 was assessed as being legally blind due to his diagnosis of diabetic retinopathy. C1 was assessed as needed assistance with self-administration of nasal sprays. C1 was assessed as needed assistance with laundry and housekeeping. C1 was assessed as having history of falls. The assessment indicated C1's services were appropriate, with no changes made to C1's services or service plan. The assessment indicated RN-E reviewed C1's service plan. C1's incident report dated December 22, 2020, at 9:25 a.m., and completed by RN-E, indicated ULP-C was getting C1 dressed for a scheduled doctor's appointment at 12:00 p.m., when she noticed necrosis on C1's right big and second toes. RN-E, sent a note with C1 asking C1's	0 865		

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	H31955	A. BUILDING: _____ B. WING _____	C 05/11/2021

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0 865	Continued From page 9 physician to assess C1's right foot during his scheduled appointment. The incident report indicated after being seen by his physician, C1 was admitted to a local hospital with a diagnosis of gangrene of the right foot. The report indicated C1's family member (FM)-G was notified at 12:00 p.m. on December 22, 2020. Review of C1's clinic medical record dated December 22, 2020, indicated C1's physician received a note from the licensee, requesting the doctor assess C1's right big toe during his scheduled doctor's appointment. The progress note indicated C1's toes were completely black in color. C1's right extremity was cold with absent distal pulses, along with redness and swelling on top of his foot. C1 denied being in pain and said he never paid attention to his feet. Review of the licensee internal investigation conducted on December 22, 2020, indicated ULP-F did not perform checks with C1's feet because C1 always wore socks. Review of C1's hospital record dated December 22, 2020, indicated C1 was seen at his primary physician earlier in the day for a scheduled cortisone shot due to left shoulder pain. The hospital record indicated C1 arrived at his clinic appointment with a note from licensee nursing staff to "take a look at his right big toe." C1 said he never noticed any discoloration of his toes. The hospital record indicated C1 stated, "a nurse is supposed to look at my feet every day, but they don't look at my toes for three weeks at a time." The hospital record indicated C1 had extensive gangrenous changes involving his right forefoot. C1's hospital record indicated on December 25, 2020, C1 underwent a transmetatarsal amputation of his right foot.	0 865		

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	H31955	A. BUILDING: _____ B. WING _____	C 05/11/2021

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0 865	Continued From page 10 During an interview on May 11, 2021, at 1:45 p.m., housing unit coordinator (HUC)-D said she was in charge of overseeing ULP to ensure they were performing scheduled client services. HUC-D said there were over 90 clients in the licensee building she was responsible for. HUC-D said it was her to job to ensure services were getting done in a timely manner. HUC-D said she checked weekly to see if services were done, but only checked the services flagged as partially complete, or not completed. HUC-D said when she first started in June 2020, "it wasn't getting done." During an interview on May 11, 2021, RN-E said she started working as a nurse manager in June 2020, after obtaining her registered nurse license. RN-E said her job responsibilities included communicating with client's physicians, performing assessments, and making sure clients services were getting done. RN-E said she started to see a decline in C1 in October 2020. RN-E said around that time C1 required more assistance from ULP due to being physically unable to transfer himself out of bed. RN-E said ULP had to assist him in sitting up in bed. RN-E said ULP complained about C1's heaviness with transfers and his increased cares. During an interview on May 11, 2021, director of nursing (DON)-B said C1 required "hands-on assist" with all activities of daily living (ADL)'s and transfers. During an interview on May 11, 2021, at 2:45 p.m., executive director (ED)-A said she noticed a "huge decline" with C1 in June 2020, when he returned back to the licensee after a month-long stay at a local transitional care unit (TCU). ED-A	0 865		

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	H31955	A. BUILDING: _____ B. WING _____	C 05/11/2021

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0 865	Continued From page 11 said C1's family was aware and agreed to the services in C1's service plan. During an interview on May 17, 2021, at 9:00 a.m., ULP-F said C1 required assistance with everything and used only a wheelchair for mobility. During an interview on May 20, 2020, at 10: a.m., FM-H said during the time C1 resided at the licensee, she had many care conferences with administration discussing C1's cares, including C1's reports of not receiving his scheduled twice weekly showers. During an interview on June 9, 2021, at 11:43 a.m., ULP-C said C1 transferred himself in and out of his bed to his chair and stood by if he needed help. ULP-C said during the days C1 had dialysis, his meals would be left inside his apartment for him to heat in his microwave. ULP-C said it upset her that his food was left in his room, so she would bring his meals to him after he arrived back from dialysis. ULP-C said C1 was not on a special diet and ate the same food as everyone else. During an interview on June 10, 2021, at 11:00 a.m., C1 said he was not happy with the cares he received while residing at the licensee. C1 stated, "they were supposed to look at my feet, and they wouldn't look at my feet for days. The doctors had it written down I was supposed to get my feet checked every day." C1 said on the morning of December 22, 2020, he was scheduled for a shower, stating, "I was supposed to get a shower on a Tuesday, (December 22, 2020), and they (ULP) said, your foot is black." C1 said at times he received assistance with transfers, and other times he transferred himself using his walker,	0 865		

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0 865	Continued From page 12 indicating ULP did not respond to his pendant calls in a timely manner. Review of the licensee website, copyrighted 2021, indicated nursing staff provided services ordered by physicians and agreed to in the client's service plan. Review of the nurse manager job description dated and signed on June 12, 2020, indicated the nurse manager was responsible for communicating client change in conditions to physicians, assuring physician orders were signed and implemented within 24 hours, and monitoring ULP for compliance of clients' scheduled services and home care procedures. The licensee policy titled Service Plans, dated July 10, 2017, defined "service plan" as a written plan between a client or client's designated representative, and the home care licensee about services that were provided to the client. Staff providing home care services were informed of a client's current written service plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 865		
01045 SS=G	144A.4793, Subd. 5 Documentation of Treatment/Therapy Subd. 5.Documentation of administration of treatments and therapies. Each treatment 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	01045		

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01045	Continued From page 13 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 record review, the licensee failed to ensure physician's orders were implemented and documented for one of one client (C1 reviewed). Nursing staff failed to follow-up and notify C1's out-of-range blood glucose levels to C1's physician as ordered in C1's medical record. C1 required amputation of his right lower extremity after developing gangrene in his right toes. 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 was issued at a 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). Findings Include: BLOOD GLUCOSE LEVELS C1's medical record was reviewed. C1's diagnoses included, but were not limited to, End Stage Renal Disease (ESRD), diabetic neuropathy, bilateral diabetic retinopathy, type 2 diabetes mellitus with chronic kidney disease (CKD), peripheral vascular disease (PVD), difficulty in walking, and bilateral legal blindness. C1's medical record indicated C1 used a walker	01045		

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01045	Continued From page 14 and wheelchair for mobility. C1's Individual Abuse Prevention Plan dated March 26, 2020, indicated C1 was assessed as legally blind related to C1's diagnoses of diabetic neuropathy. Needed intervention and goal included staff assisted C1 with daily activities involving vision and C1 would remain safe despite vision deficits. C1 was assessed as vulnerable to mobility related to left foot toes amputation, and could only self-propel short distances in his wheel chair. Needed intervention included staff encouraged C1 to use ambulation device at all times when ambulating and provided physical assistance in the event of an emergency. Goals included C1 would remain safe when ambulating, safe in his environment, and free from falls. C1 was assessed as being vulnerable related to ESRD, arthritis, and dialysis. Needed interventions included C1 would have regular check-ups with his physician and take medications as prescribed. Staff were to notify a nurse promptly for any changes in C1's condition. Goal included C1 would experience comfort, no pain, and have stabilization of his chronic medical conditions if possible. C1 was assessed as vulnerable due to relying on others for assistance with his activities of daily living (ADL)'s, medication management, transportation, finances, and maintenance of safe, clean environment. Needed intervention included staff monitored and reported promptly to nurse any signs of abuse or neglect. Goal included C1 would remain free from abuse and neglect while residing at the facility. Review of C1's physician order sheet dated September 21, 2020, indicated on June 19, 2020, C1's physician ordered twice daily blood glucose checks and notification from a licensee nurse	01045		

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01045	Continued From page 15 whenever C1's blood glucose readings fell below 60 mg/dL or above 300 mg/dL, in addition to weekly faxed blood glucose results. On the last page, C1's physician included a hand-written note, requesting nursing staff to, "please inform when blood sugars are over 300 milligrams per deciliter (mg/dL). I see two readings in 500's." Review of C1's medical record provided by the licensee for C1 did not include documentation C1's physician was notified regarding C1's blood sugars readings above 300 mg/dL. C1's incident report dated October 14, 2020, at 4:30 p.m., indicated ULP found streaks of blood on the floor inside C1's apartment after he returned from dialysis. C1 was unaware he had injured himself. Registered nurse (RN)-E assessed C1 and found two skin tears, one on his right big toe measuring 0.6 centimeters (cm) x 0.6 cm. The second skin tear was on his second right toe, measuring 0.3 cm x 0.3 cm. C1's wounds were cleansed and bandaged. RN-E instructed C1 to be more cautious with his legs and feet when transferring and ambulating. Review of C1's wound chart assessment, dated October 14, and October 22, 2020, indicated RN-E performed wound care for C1's skin tears on his right foot once, on October 14, 2020. Documentation for October 14, 2020 indicated both wounds had granulation skin tears, and medium drainage of red blood. C1 responded well and denied pain. October 22, 2020 documentation for wound care written by RN-E had the entry, "wound scabbed over." No other documentation was entered for C1's wound cares. C1's progress note dated November 19, 2020, at	01045		

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01045	Continued From page 16 9:01 a.m., indicated C1's physician sent a faxed communication to RN-E requesting RN-E contact C1's family to schedule a telehealth visit related to C1's elevated blood sugars. The progress note indicated RN-E left a voice message for C1's family member. Review of C1's progress notes provided by the licensee did not include documentation a telehealth visit was scheduled. C1's service plan, dated December 1, 2020, indicated C1 received assistance with personal cares, medication management, meals, including meal set-up, transfer assist of one, housekeeping, daily safety checks, twice daily blood glucose checks, and three times weekly dialysis treatments. C1's service plan indicated unlicensed personnel (ULP) were to notify a RN immediately for any blood glucose readings below 70 or above 300 milligrams per deciliter (mg/dL). C1's blood glucose results were to be faxed weekly to C1's physician. C1's service plan indicated ULP were to inspect C1's feet daily when changing C1's socks, and twice weekly during bathing assistance on Tuesdays and Saturdays. Inspection of C1's feet included inspecting both feet (top and bottom) for open areas, changes in color, swelling, or any area of concern. Changes in C1's feet were to be reported immediately to a nurse. Licensee staff were to update a nurse immediately if C1 refused to change his socks. C1's medication administration record (MAR) dated December 2020, indicated C1 received daily injections of Lantus Solostar 100 Units/milliliter (mL); 8 Units under the skin at bedtime (HS) related to his Type 2 diabetes mellitus and CKD. C1 received blood glucose	01045		

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01045	Continued From page 17 monitoring at 7:15 a.m. and 4:30 p.m. C1's MAR indicated ULP were to notify nurse when C1's blood sugars fell below 60 mg/dL or above 300 mg/dL. A licensee nurse was to notify C1's physician for any out-of-range blood glucose levels below 60 mg/dL or above 300 mg/dL. Review of C1's blood glucose readings indicated between September 15, 2020 and December 22, 2020, C1 had 27 recorded blood glucose levels above 300 mg/dL on the following dates: 09/15/20: 505 mg/dL at 4:13 p.m. 09/18/20: 505 mg/dL at 4:13 p.m. 10/08/20: 351 mg/dL at 4:11 p.m. 10/18/20: 484 mg/dL at 4:01 p.m. 10/19/20: 321 mg/dL at 3:50 p.m. 10/22/20: 525 mg/dL at 3:41 p.m. 10/24/20: 419 mg/dL at 3:43 p.m. 10/31/20: 305 mg/dL at 3:42 p.m. 11/05/20: 316 mg/dL at 4:04 p.m. 11/10/20: 347 mg/dL at 1:11 p.m. 11/10/20: 383 mg/dL at 4:00 p.m. 11/14/20: 418 mg/dL at 4:45 p.m. 11/15/20: 429 mg/dL at 4:25 p.m. 11/17/20: 363 mg/dL at 4:12 p.m. 11/20/20: 343 mg/dL at 3:49 p.m. 11/22/20: 432 mg/dL at 4:13 p.m. 11/24/20: 414 mg/dL at 3:45 p.m. 11/26/20: 377 mg/dL at 4:03 p.m. 11/27/20: 322 mg/dL at 4:00 p.m. 11/28/20: 328 mg/dL at 4:16 p.m. 12/03/20: 393 mg/dL at 3:57 p.m. 12/05/20: 312 mg/dL at 5:17 p.m. 12/10/20: 306 mg/dL at 3:38 p.m. 12/13/20: 350 mg/dL at 4:35 p.m. 12/14/20: 339 mg/dL at 8:22 and 8:50 a.m. 12/15/20: 548 mg/dL at 8:15 a.m. Review of C1's medical record provided by the licensee for C1 did not include documentation	01045		

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01045	Continued From page 18 C1's physician was notified regarding C1's out-of-range blood glucose levels. C1's incident report dated December 22, 2020, at 9:25 a.m., and completed by RN-E, indicated ULP-C was getting C1 dressed for a scheduled doctor's appointment at 12:00 p.m., when she noticed necrosis on C1's right big and second toes. RN-E, sent a note with C1 asking C1's physician to assess C1's right foot during his scheduled appointment. The incident report indicated after being seen by his physician, C1 was admitted to a local hospital with a diagnosis of gangrene of the right foot. The report indicated family member (FM)-G was notified at 12:00 p.m. on December 22, 2020. Review of C1's clinic medical record dated December 22, 2020, indicated C1's physician received a note from the licensee, requesting the doctor assess C1's right big toe during his scheduled doctor's appointment. The progress note indicated C1's toes were completely black in color. C1's right extremity was cold with absent distal pulses, along with redness and swelling on top of his foot. C1 denied being in pain and said he never paid attention to his feet. Review of the licensee internal investigation conducted on December 23, 2020, indicated the following ULP's were interviewed regarding C1's foot checks during twice weekly showers and daily dressing assistance: ULP-I said she did not see any black toes on C1's feet. ULP-F said C1 always wore socks so he was not able to check his feet. ULP-F said on December 19, 2021, during the evening shift while changing C1's socks, he noticed C1's right big toe was black at the top. ULP-F said he did not report it to a nurse since he thought it was normal for clients with	01045		

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01045	Continued From page 19 diabetes. Review of C1's hospital record dated December 22, 2020, indicated C1 was seen at his primary physician earlier in the day for a scheduled cortisone shot due to left shoulder pain. The hospital record indicated C1 arrived at his clinic appointment with a note from the licensee to "take a look at his right big toe." C1 said he never noticed any discoloration of his toes. The hospital record indicated C1 stated, "a nurse is supposed to look at my feet every day, but they don't look at my toes for three weeks at a time." The hospital record indicated C1 had extensive gangrenous changes involving his right forefoot. During an interview on May 11, 2021, at 11:00 a.m., ULP-C said C1 was "with it", but he could not see, stating, "he could hardly see anything in front of him." During an interview on May 11, 2021, at 1:45 p.m., housing unit coordinator (HUC)-D said she was in charge of overseeing ULP to ensure they were performing scheduled client services. HUC-D said there were over 90 clients in the licensee building she was responsible for. HUC-D said it was her to job to ensure services were getting done in a timely manner. HUC-D said she checked weekly to see if services were done, but only checked the services flagged as partially complete or not done. HUC-D said when she first started in June 2020, "it wasn't getting done." During an interview on May 11, 2021, at 2:45 p.m., executive director (ED)-A said C1's family was aware and agreed to the services in C1's service plan. ED-A said she did not know specifically what happened, on December 22, 2020, but said when ULP-C discovered C1's	01045		

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01045	Continued From page 20 blackened right toes she assumed RN-E would assess his foot, call the provider, perform wound care, then send him out, stating, "that's standard protocol." During an interview on May 13, 2021, at 1:33 p.m., RN-E said communications with C1's physician, including out-of-range blood sugars, were documented in progress notes. During an interview on May 17, 2021, at 1:00 p.m., FM-G said on the morning of December 22, 2020, he met C1 at his scheduled doctor's appointment. C1 told FM-G, "I have a doctor's appointment this afternoon, they're going to look at my foot." FM-G asked C1 what was wrong with his foot, and C1 replied a staff person told him his right foot was black. FM-G said two days earlier, C1 was told by ULP his right toes were black. FM-G said when he saw C1's right foot his toes looked like, "two charcoal briquettes." C1 was immediately hospitalized with extensive gangrene of the right foot. FM-G said the licensee never called ahead to alert C1's family on the condition of his right foot. During an interview on May 20, 2021, at 10:00 a.m., FM-H said on December 22, 2020, C1 used a medical transport company to take him to his scheduled doctor's appointment. FM-H said the licensee never told her about C1's right foot until hours later when C1 was at the doctor's office. During an interview on June 7, 2021, at 11:26 a.m., RN-E said she was unsure if a telehealth visit was scheduled between C1's family and his physician. RN-E said she never attempted to call the family again after leaving the voice message. RN-E said if she did, it would have been documented in a progress note. RN-E said	01045		

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01045	Continued From page 21 out-of-parameter blood sugars were reported to the provider, but said after November 19, 2020, C1's blood sugars appeared stable to her. RN-E said the licensee's parameters for reporting out-of-range blood sugars were blood glucose readings below 70 mg/dL or above 400 mg/dL, but said ultimately it was C1's physician who set the parameters. During an interview on June 7, 2021, at 3:09 p.m., FM-G said she did not recall the licensee contacting her to schedule a telehealth visit with C1's physician, stating the family would have followed through with the request for a telehealth visit. During an interview on June 10, 2021, at 11:00 a.m., C1 said he was not happy with the cares he received while residing at the licensee. C1 stated, "they were supposed to look at my feet, and they wouldn't look at my feet for days. I was supposed to get a shower on a Tuesday, (December 22, 2020), and they (ULP) said, "your foot was black." C1 said at times he received assistance with transfers, and other times he transferred himself using his walker, indicating his requests for assistance using his call pendant would be delayed. C1 said he wrote down on paper the times he did not get his feet checked. During an interview on June 10, 2021, at 11:00 a.m., C1 said he was not happy with the cares he received while residing at the licensee. C1 stated, "they were supposed to look at my feet, and they wouldn't look at my feet for days. The doctors had it written down I was supposed to get my feet checked every day. C1 said on the morning of December 22, 2020, he was scheduled for a shower, stating, "I was supposed to get a shower on a Tuesday, (December 22, 2020), and they	01045		

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01045	Continued From page 22 (ULP) said, your foot is black." C1 said at times he received assistance with transfers, and other times he transferred himself using his walker, indicating ULP did not respond to his pendant calls in a timely manner. The licensee policy titled Service Plans, dated July 10, 2017, defined "service plan" as a written plan between a client or client's designated representative, and the home care licensee about services that were provided to the client. Staff providing home care services were informed of a client's current written service plan. Review of the nurse manager job description dated and signed on June 12, 2020, indicated the nurse manager was responsible for communicating client change in conditions to physicians, assuring physician orders were signed and implemented within 24 hours, and monitoring ULP for compliance of clients' scheduled services and home care procedures. TIME PERIOD TO CORRECT: Seven (7) Days	01045		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	02015		

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02015	Continued From page 23 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The	02015		

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02015	Continued From page 24 lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of four clients (C1) reviewed. C1 had out-of-range uncontrolled blood sugars that were not reported in a timely manner to C1's physician. C1 developed gangrene on his right foot, was hospitalized, and later had amputation of his right lower extremity. 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). Findings include: C1's medical record was reviewed. C1's diagnoses included, but were not limited to, End Stage Renal Disease (ESRD), diabetic neuropathy, bilateral diabetic retinopathy, type 2 diabetes mellitus with chronic kidney disease (CKD), peripheral vascular disease (PVD), difficulty in walking, and bilateral legal blindness. C1's medical record indicated C1 used a walker and wheelchair for mobility. C1's Individual Abuse Prevention Plan dated	02015		

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02015	Continued From page 25 March 26, 2020, indicated C1 was at risk for being abused. C1 was assessed as legally blind and required assistance with his activities of daily living (ADL)'s. C1's mobility was impaired due to previous left toes amputation, vision impairment, and history of falls. Licensee staff were to monitor for any signs of neglect from others and report to the registered nurse (RN) promptly for any changes in condition. Review of C1's physician orders indicated on June 19, 2020, C1's physician ordered twice daily blood glucose checks and notification from a licensee nurse whenever C1's blood glucose readings fell below 60 mg/dL or above 300 mg/dL, in addition to weekly faxed blood glucose results. Review of C1's blood glucose readings dated October 1, 2020 though December 22, 2020, indicated C1 had 25 blood glucose readings above 300 milligrams per deciliter (mg/dL). Review of C1's medical record provided by the licensee for C1 did not include documentation C1's physician was notified regarding C1's out-of-range blood glucose levels. C1's progress note dated November 19, 2020, at 9:01 a.m., indicated C1's physician sent a faxed communication to RN-E requesting RN-E contact C1's family to schedule a telehealth visit related to C1's elevated blood sugars. The progress note indicated RN-E left a voice message for C1's family member. A review of C1's progress notes provided by the licensee did not include documentation a telehealth visit was scheduled.	02015		

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02015	Continued From page 26 C1's service plan, dated December 1, 2020, indicated C1 received assistance with personal cares, medication management, transfer assist of one, housekeeping, daily safety checks, twice daily blood glucose checks, and three times weekly dialysis treatments. C1 used a wheelchair and walker for mobility. C1's service plan indicated unlicensed personnel (ULP) were to notify a immediately for any blood glucose readings below 70 or above 300 milligrams per deciliter (mg/dL). C1's blood glucose results were to be faxed weekly to C1's physician. C1's service plan indicated ULP were to inspect C1's feet daily when changing C1's socks, and twice weekly during bathing assistance on Tuesdays and Saturdays. Inspection of C1's feet included inspecting both feet (top and bottom) for open areas, changes in color, swelling, or any area of concern. Changes in C1's feet were to be reported immediately to a nurse. ULP staff were to update a nurse immediately if C1 refused to change his socks. C1's incident report dated December 22, 2020, at 9:25 a.m., and completed by RN-E, indicated ULP-C was getting C1 dressed for a scheduled doctor's appointment at 12:00 p.m., when she noticed necrosis on C1's right big and second toes. ULP-C notified RN-E, who alerted C1's physician to assess C1's right foot during his scheduled appointment. The incident report indicated after being seen by his physician, C1 was admitted to a local hospital with a diagnosis of gangrene of the right foot. Review of the licensee internal investigation conducted on December 22, 2020, indicated ULP's who performed cares for C were interviewed regarding C1's cares, including feet inspection. ULP-I said she did not see any black	02015		

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02015	Continued From page 27 toes on C1's feet. ULP-F said while working the evening shift on December 19, 2021, he noticed C1's right big toe was black at the top when he changed C1's socks, but said he did not report it to a nurse since he thought it was normal for clients with diabetes. ULP-F said C1 always wore socks so he was not able to check his feet. Review of C1's clinic medical record dated December 22, 2020, indicated C1's physician received a note from the licensee, requesting C1's physician assess C1's right big toe during his scheduled clinic appointment at 12:00 p.m. that day. The progress note indicated C1's physician noticed C1 had developed gangrene on his right big toe and second toe. The progress note indicated C1's toes were completely black in color. C1's right extremity was cold with absent distal pulses, along with redness and swelling on top of his foot. The progress note indicated C1 said he never noticed discoloration on his right foot and denied being in pain. C1 said he never paid attention to his feet. C1 told his physician his feet were to be examined daily, but said his feet were not checked for weeks. During an interview on May 11, 2021, at 11:00 a.m., ULP-C said C1 was "with it", but he could not see, stating, "he could hardly see anything in front of him." During an interview on May 13, 2021, at 1:33 p.m., RN-E said communications with C1's physician, including out-of-range blood sugars, were documented in progress notes. The licensee policy titled, Maltreatment of a Vulnerable Adult-Communication, Prevention, and Reporting, dated March 29, 2019, indicated licensed staff would report any from of suspected	02015		

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02015	Continued From page 28 neglect or abuse to the RN or Executive Director (ED), or call MAARC directly. The licensee RN or ED would immediately make an oral or written report to MAARC. Immediately meant as soon as possible and no longer than 24 hours. TIME PERIOD TO CORRECT: Seven (7) days.	02015		