Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343077924M
Compliance #: HL343074863C

Date Concluded: May 3, 2024

Name, Address, and County of Licensee Investigated:
Olydia Home Care Inc.
7243 Morgan Ave. North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when staff failed to turn and reposition the resident resulting in progression and worsening of the resident's wounds and limb amputation. In addition, nursing staff did not follow proper infection control procedures related to catheter care, resulting in multiple urinary tract infections.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility did not oversee wound management services and failed to assess, monitor, and provide necessary care to promote healing and/or prevent worsening of the resident's wounds. The resident's wounds progressed resulting in multiple hospitalizations and amputation. Concerns related to catheter care and infection control procedures were also reviewed; however, due to inconsistent information and a lack of documentation provided, it was unable to be determined if maltreatment occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's case worker and outside skilled nursing agency staff. The investigation included review of the resident's record, hospital records, personnel files, staff schedules, and facility policies and procedures. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included tetraplegia (paralysis that affects both arms and both legs) and the use of a suprapubic catheter (a tube used to drain urine from the bladder through a cut in the abdomen). The resident's service plan indicated the resident was cognitively intact, required the assistance of two staff for mobility, dressing, grooming, toileting, and every two-hour repositioning.

The resident admitted to the facility with wounds managed by an affiliated homecare agency. The resident's medical record indicated the resident had a heavily draining wound that required daily care, but the location of the wound was not identified. The resident's medical record also lacked an assessment(s), description, measurement of the wound(s), and included no wound treatment orders. There was no evidence of communication or collaboration of care between the facility and homecare agency staff.

Six months after admission, the resident was hospitalized and diagnosed with cellulitis (skin infection), osteomyelitis (infection of the bone) and severe sepsis (systemic infection). Hospital records identified that the resident had extensive wounds on both feet and a worsening chronic pressure ulcer. The resident's left ankle had a large ulcer or abscess on the back of the foot with possible sepsis of the left Achille's tendon. The resident's left heel abscess was drained, and the fifth toe was amputated from the left foot. The resident underwent amputation of the fourth and fifth toes of the right foot. Hospital documentation indicated that prior to discharging the resident back to the facility, the facility staff indicated that they were able to manage the resident's care. Hospital discharge orders indicated that the resident was discharged with a peripherally inserted central catheter (PICC) line that was placed for extended administration of intravenous (IV) antibiotics, oral antibiotics to treat infection and that the care and treatment of the amputated areas included the use of vacuum-assisted closure (wound vac) devices to be managed by a home health agency.

Upon the resident's return to the facility, the resident's medical record was not updated to include information regarding the resident's hospitalization, the amputation of the fourth and fifth toes, wound vac treatments, PICC line care and management, the IV and oral antibiotic use, and did not identify the location or description of the wounds. The resident's medical record lacked evidence that follow-up nursing care, ongoing assessment or monitoring of the resident's amputation sites, monitoring of the PICC line insertion site, and monitoring of the resident's infection status was completed by facility nursing staff. There was no evidence of communication or collaboration of care between the facility and a homecare agency or evidence that the initial homecare agency was still involved in the resident's care.

Approximately four months later, the resident was transported to the emergency room due to wound concerns. Hospital records indicated the resident's heel wound dressings had not been changed over the last five or six days and the resident's left ankle wound had foul-smelling purulent (thick yellow or green) drainage. The resident was diagnosed with cellulitis and underwent left above-the-knee leg amputation. The resident discharged back to the facility with orders for wound care to be completed by an outside skilled nursing home care agency.

Upon readmission to the facility, the resident's medical record was not updated to include documentation of the resident's hospitalization, the above-the-knee amputation, location or description of the wound(s), and did not include wound care treatment orders. The medical record also did not indicate if the resident required additional assistance or had a change in care needs following the recent amputation and there was no evidence that follow-up care, ongoing assessment, or monitoring of the resident's wounds was completed by facility nursing staff.

During an interview, the resident stated two staff were required to complete his cares and when two staff were not available, he "went without." The resident stated that the lack of turning and repositioning and lack of wound care led to the worsening of his wounds and ultimately the leg amputation(s). The resident stated that he didn't think he would be alive if the skilled agency nurses hadn't taken over the management of his wounds.

During investigative interviews, skilled agency nursing staff stated the resident required every two-hour turning and repositioning to promote healing and to prevent the development of additional wounds. The skilled agency nurses stated that it was evident that facility staff were not completing the resident's care because the resident's coccyx wound was not healing, new wounds developed, and two staff were not scheduled to work at all times. The skilled agency nurses stated communication with the facility was poor and facility management didn't answer the phone when attempts were made to coordinate the resident's care.

During an interview, the facility nurse verified two staff were not always available to provide the necessary care for the resident. The facility nurse stated that the resident did not want the facility involved in his care. The nurse stated the resident yelled at staff and refused cares, including turning and repositioning.

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

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

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

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

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

Action taken by facility:
None.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34307	A. BUILDING: _____ B. WING _____	C 02/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLYDIA HOME CARE INC	7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: # HL343074863C /# HL343077924M On February 12, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for # HL343074863C /# HL343077924M, tag identification 0470, 0510, 1420 and 2310.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to ensure sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plan for one of one resident (R1) with pressure ulcers who was assessed to require the assistance of two staff members to provide turning and repositioning care.	0 470		

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on June 8, 2022, with diagnoses of C5-C7 spinal cord injury, obesity, and history of urinary tract infection. R1's undated admission assessment, indicated R1 needed assistance of two staff for all cares including repositioning. R1's urinary status was documented as within normal limits and indicated R1 had a suprapubic catheter and did not have a history of urinary tract infections. R1's admission assessment lacked evidence R1 had any skin concerns. R1's service plan dated July 8, 2022, indicated R1 required assistance with bathing, dressing, toileting, bed mobility and medication administration. R1's treatment records dated July 1, 2023, indicated R1 received assistance of two staff with turning and repositioning every 2 hours and as needed. R1's medical record did not include an updated service plan to reflect the change in care needs and the required assistance of two staff.	0 470		

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0 470	Continued From page 3 The facility's undated staffing schedule titled "Week 1," indicated one unlicensed personnel (ULP) was scheduled for 7:00 a.m. to 9:00 p.m., another ULP was scheduled 8:00 a.m. to 4:00 p.m., and only one ULP was scheduled 7:00 p.m. to 7:00 a.m. Two staff were not consistently scheduled to be available to complete R1's cares. During an observation on February 12, 2024, at 9:17 a.m. The MDH investigator noted the licensee had no posted staffing schedule available in the facility and unlicensed personnel (ULP)-F was the only staff working at the time of the MDH investigator's visit. At 9:40 a.m. ULP-F and registered nurse (RN)-D repositioned R1. At 11:30 a.m. ULP-F repositioned R1 independently. At 12:07 p.m. ULP-G arrived. No additional repositioning was completed on R1. At 3:00 p.m. ULP-F left the licensee and ULP-G was the only staff remaining to work in the facility. ULP-F reported to the MDH investigator that ULP-G was on "light duty" due to an injury. During an interview on February 13, 2024, at 11:32 p.m. the licensee's registered nurse (RN)-B stated R1 was supposed to turned and repositioned every two hours and acknowledged staff were not always able to complete every two hour turning and repositioning due to only one staff being available and working alone in the building. During an interview on February 16, 2024, 8:19 a.m. R1's case manager (CM)-D stated the licensee was getting paid for two staff to be available to provide cares for R1. During an interview on February 23, 2024, at 10:00 a.m. an outside agency registered nurse (RN)-E invovled in R1's care stated R1 was	0 470		

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0 470	Continued From page 4 supposed to be turned and repositioned every two hours and R1 required two staff to complete R1's turning and repositioning. RN-E stated "a lot of times" the licensee only had one staff working. RN-E stated she would ask if R1 had been turned or repositioned and R1 would say no. This was evident by R1's coccyx wound not healing. RN-E stated one-night R1 had to sleep in his wheelchair because the night staff couldn't transfer R1 to his bed. During an interview February 15, 2024, at 1:00 p.m. a facility registered nurse (RN)-A stated the licensee focused on patient center care and had 2 staff in the building for 12 hours a day "or so." RN-A indicated that during the overnight shift there was only 1 staff member in the building. RN-A verified R1 needed 2 staff for repositioning. The licensee's uniform disclosure of assisted living services and amenities (UDALSA) document dated July 8, 2023, indicated the licensee provided the service of transfer assistance of two staff and this service was available to the residents. The licensee's policy dated August 1, 2021, titled "4.06 Staffing & Scheduling," indicated the clinical nurse supervisor must ensure that staffing levels are adequate to address each resident's needs, as identified in the resident's service plan and assisted living contract, each resident's acuity level, the ability of staff to timely meet the resident's scheduled and unscheduled needs, and staff experience, training, and competency. The daily work schedule must be posted. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control. This had the potential to affect all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident'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 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to the assisted living on June 8, 2022, with diagnoses of C5-C7 spinal cord injury, obesity, and history of urinary tract infection.	0 510		

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0 510	Continued From page 6 R1's undated admission assessment, indicated R1 required the assistance of two staff for all cares including positioning and utilized a suprapubic catheter. R1's medical record did not include evidence of a treatment record that included catheter care and there was no evidence of physician's orders related to catheter care or scheduled on changing the catheter. R1's hospital record dated July 28, 2023, indicated R1 reported headache, nausea, and central neck pain. R1 reported sediment and foul odor from his catheter and the catheter was last changed at the time of his last hospitalization. R1 stated the facility registered nurse (RN)-A attempted to change his catheter the day prior but didn't have the correct size, so RN-A removed and boiled the catheter, then reinserted the catheter into R1. In the hospital, R1's catheter was replaced, and antibiotics were started to treat a urinary tract infection. Review of R1's record prior to the July 2023 hospitalization included no documentation of symptoms, monitoring, or assessment of R1 prior to his transfer to the hospital. R1's medical records lacked evidence of the catheter change completed by RN-A. R1's medical record was not updated to indicate R1 was hospitalized related to a urinary tract infection and contained no evidence of monitoring following the hospitalization. During an interview February 13, 2024, at 11:32 a.m,. an outside agency registered nurse (RN)-B involved in R1's care, recalled an incident that	0 510		

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0 510	Continued From page 7 occurred a few months back, when the licensee's nurse boiled a catheter after it got contaminated and reinserted back into R1 after it was boiled. R1 ended up hospitalized with a urinary tract infection (UTI). During an interview February 23, 2024, at 10:00 a.m. a second outside agency registered nurse (RN)-E stated R1 had a suprapubic catheter that was managed by the licensee. R1 kept getting UTIs and one day he wanted to go to the hospital because he was feeling sick. RN-E recalled that the facility nurse (RN-A) told R1 she needed to change the catheter before R1 went to the hospital and she removed the catheter, boiled the catheter, and replaced the catheter into R1. During an interview February 15, 2024, at 1:00 p.m. RN-A stated R1 was bypassing and having autonomic symptoms (dysfunction of the nerves that regulate nonvoluntary body functions, such as heart rate, blood pressure, and sweating.) so we sterilized the back up catheter in attempt to relieve R1's symptoms. RN-A stated she followed the licensee sterilization procedure before reinserting R1's catheter. The licensee's policies for infection control and the catheter sterilization procedure were requested but not provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services	01420		

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01420	Continued From page 8 (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP-F) who utilized a sit to stand lift for transferring R7. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Unlicensed Personnel (ULP)-F was hired on August 9, 2021, to provide direct care services to the facility's residents.	01420		

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01420	Continued From page 9 On November 28, 2022, at 2:15 p.m., the surveyor observed ULP-F and ULP-E, using appropriate transfer techniques when transferring R7 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). ULP-F's employee record lacked documentation to indicate ULP-F was trained and demonstrated competency for using the sit to stand lift. On November 30, 2022, at 5:08 p.m., the registered nurse (RN)-C stated the facility had no documentation of ULP-F being trained and deemed competent for using the sit to stand lift and RN-C did not know if any training or competency testing had been completed. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted a RN may delegate nursing services, or an authorized Licensed Health Professional may delegate treatments or assign therapy tasks, to ULP that: i. have successfully completed the training required for ULP, ii. have trained in the services to be provided, iii. have demonstrated to the RN or Licensed Health Professional the ability to competently follow the procedures for the client and possess the knowledge and skills consistent with the complexity of the task No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		

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OLYDIA HOME CARE INC	7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

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02310	Continued From page 10	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards for one of one resident (R1) reviewed. R1's medical record did not contain an up-to-date service plan and also lacked documentation and additional assessment and monitoring after R1's multiple hospitalizations, progressing wounds, PICC line and antibiotic use, wound vacuum device use, and above-the-knee amputation. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: R1 was admitted to the assisted living on June 8, 2022, with diagnoses of C5-C7 spinal cord injury, obesity, and history of urinary tract infection.	02310		

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02310	Continued From page 11 R1's undated admission assessment, indicated R1 required the assistance of two staff for all cares including positioning. R1's admission assessment lacked evidence R1 had any skin concerns. R1's undated provider worksheet for customized living completed by a facility registered nurse (RN)-A, indicated R1 required the assistance of two staff with dressing twice daily and as needed. RN-A documented that "It takes at least 2 staff to get him dressed." One staff was needed to raise R1's lower extremities while the other staff puts on R1's pants. R1 takes a lot of time to pull up pants while turning him side to side to preserve his wound. R1 was assist of two with bed bath at least once daily and has needed due to heavily draining wound. R1 was assist of two with transfer and hoyer lift "several" times daily and as needed. The provider workisheet indicated clinical monitoring was required and indicated wound assessments were to be completed weekly for wound management and monitoring of ostomy site. R1 was to receive weekly systemic assessments due to weight loss and multiple comorbidities. R1's service plan did not reflect R1's need for assistance of two staff for turning and repositioning. R1's service plan dated July 8, 2022, indicated R1 required assistance with bathing, dressing, toileting, bed mobility and medication administration. R1's service plan lacked evidence of wound care management. R1's treatment records dated July 1, 2023, indicated R1 received assistance of two staff with turning and repositioning every two hours and as needed. R1's treatment records did not reflect treatment orders for wound care.	02310		

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02310	Continued From page 12 R1's medical records lacked evidence that wound assessments and systemic assessments were completed. During an observation on February 12, 2024, at 9:17 a.m., unlicensed personnel (ULP)-F was the only staff working at the licensee. At 9:40 a.m. ULP-F and RN-D repositioned R1. At 11:30 a.m. ULP-F repositioned R1. At 12:07 p.m. ULP-G arrived. No additional repositioning was provided to on R1 between 12:07 p.m. and 3:00 p.m.. At 3:00 p.m. ULP-F left the licensee and ULP-G was left alone in the building. ULP-F reported ULP-G was on "light duty" due to an injury. R1's hospital records dated January 10, 2023, indicated R1 arrived at the hospital from the facility with a fever. R1 was hypotensive 80s/40s and tachycardic 100s in route to the hospital. R1 was diagnosed with severe sepsis. R1's hospital record indicated R1 had extensive wounds on his bilateral feet and a chronic decubitus ulcer with acute worsening. R1's right foot showed osteomyelitis if the fourth and fifth toes. R1's left foot showed osteomyelitis of the fifth toes. R1's left ankle showed large ulceration of the left hindfoot and possible sepsis of the left achilles. R1's decubitus ulcer identified chronic osteomyelitis. R1 underwent a metatarsal amputation of the right foot related to osteomyelitis in the fourth and fifth metatarsal. R1 had a left heel incision and drainage completed and left fifth ray amputation. R1's medical records indicated a home care agency was managing R1's wounds but they had scheduling conflicts and RN-A had been on vacation for five weeks prior to the hospitalization. R1 was discharged with a PICC (peripherally inserted central catheter) line and intravenous (IV) antibiotics for	02310		

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02310	Continued From page 13 four weeks along with a two course of oral antibiotics. R1 returned to the licensee with a wound vac (Vacuum-assisted closure of a wound) on bilateral feet. R1 was discharged with orders for a home health agency to manage R1's wounds. R1's record lacked evidence of symptoms observed, the need for R1 to be transferred to the hospital, and a change in condition assessment was not completed. R1's readmission to the facility was not documented and R1 was not reassessed upon admission. R1's medical records lacked documentation of R1's hospitalization. R1's medical record also lacked documentation that R1 had an amputation completed or that R1 returned with a PICC line, IV and oral antibiotics, and bilateral wound vacs. R1's medical record lacked documentation that an individualized treatment or therapy management plan was created. R1's medical record did not identify if a home health agency was involved in the resident's wound care management and R1's record included no evidence of discharge or wound care treatment orders. R1's record included no follow-up documentation or clinical monitoring of R1's wounds, PICC line insertion site, infection status, or wound vac treatments. R1's hospital records dated May 25, 2023, indicated R1 was sent to the emergency room with concerns about decubitus wounds. R1 reported he did not feel good and his body hurt all over. Hospital records indicated R1's bilateral heel wound dressings had not been changed in 5 to 6 days and the left anterior ankle wound had	02310		

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02310	Continued From page 14 foul-smelling purulent drainage. R1 was diagnosed with cellulitis and a decubitus ulcer of the left ankle, stage 4. May 31, 2023, R1 underwent left above the knee amputation. R1 discharged back to the facility June 6, 2023, with orders for a new skilled nursing home health agency to manage wound care. R1's assessment dated June 6, 2023, lacked documentation that R1 was hospitalized or had an amputation. R1's medical record lacked documentation that an individualized treatment or therapy management plan was created. R1's medical record did not identify R1's change in condition or care needs following the above the knee ampuation and did not identify if R1 had any additional wounds present or any wound care or amputation site treatment orders. R1's record also did not identify if a skilled nursing home health agency had assumed wound care management. R1's assessment dated July 27, 2023, indicated R1 had open areas and the description section of the assessment indicated: "wound". The assessment lacked description, measurements, or location of the wound. R1's assessment indicated R1 required assist of 2 staff for transfers and was on a repositioning schedule. R1's September and December 2023 assessments indicated R1 had zero hospitalizations, surgeries, or emergency room visits. R1's skilled nursing home health records dated June 8, 2023, indicated a start of care for skilled nursing to perform wound care to R1's pressure ulcers located right ischial, right scrotum, left scrotal fold, right groin/scrotum, and perianal	02310		

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02310	Continued From page 15 wounds. The ulcers were not documented in R1's facility medical record. R1's skilled nursing home health record dated August 11, 2023, indicated R1 reported he had not received a bed bath for a week. R1's skin was visibly dirty. Skilled nurse discussed with licensee staff the need to reposition R1 every 2 hours. R1's skilled nursing home health record dated August 14, 2023, indicated R1 reported he had not been repositioned or cleaned all weekend long. R1's skilled nursing home health record dated August 28, 2023, indicated R1 had a new wound on the back of right knee. R1 reported he was not cleaned or repositioned over the weekend. R1's skilled nursing home health record dated September 2, 2023, indicated R1 had multiple stage 4 pressure ulcers on his coccyx that were chronic. Home health care nurse was managing wound cares every other day. The licensee had not been compliant with offloading to help with wound healing. R1's skilled nursing home health record dated October 23, 2023, indicated the facility RN (RN-A) had changed R1's wound dressing but did not put skin barrier on as ordered which caused and open area on the posterior side of R1's buttocks. R1's skin was red from sitting on the saturated dressing for so long with lack of repositioning. During an interview on February 12, 2024, at 10:00 a.m. unlicensed personnel (ULP)-F, stated there was one staff working during the day, one to two staff on evenings, and one staff for the	02310		

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02310	Continued From page 16 overnight shift. ULP-F stated R1 had a ceiling Hoyer lift and she was able to use the ceiling Hoyer alone. ULP-F stated R1 was supposed to be turned and repositioned every two hours by two staff but she does it independently. ULP-F stated R1 was supposed to get a bed bath this morning but it wasn't completed. ULP-F stated she documented on the computer but usually waited until the end of her shift, then logged in and documented that everything was done. During an interview on February 12, 2024, at 10:46 a.m. R1 stated he admitted to the licensee with wounds but lack of care by the licensee led to amputations and multiple hospitalizations. R1 stated he does not get turned and repositioned and occasionally does not get bathed. R1 stated the only reason he was still alive is because a new skilled nursing home care agency now managed his wounds and catheter care. R1 stated he wants to move out of the faciity but was unsure of his options. During an interview on February 13, 2024, at 11:32 a.m. the skilled nursing agency registered nurse (RN)-B stated the licensee was not compliant in the repositioning of R1 every two hours that was needed for R1's wound healing. RN-B stated during her visits there had only been one staff member scheduled by the licensee. RN-B stated she was very concerned about the care the licensee was providing and feared R1 would get another infection and go septic again. During an interview on February 16, 2024, at 8:19 a.m. R1's case manager (CM)-D stated R1 was supposed to be receiving care from the licensee and that the licensee was getting paid for two staff to assist R1. CM-D stated R1 wanted to move out as he was not happy with the care from	02310		

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02310	Continued From page 17 the licensee. During an interview on February 23, 2024, at 10:00 a.m. a skilled nursing agency registered nurse (RN)-E stated she had many concerns with the licensee and the care they provided to R1. RN-E stated the licensee would not manage wounds and did not turn and reposition R1 and that this was evident by the coccyx wound not healing. RN-E stated although the agency has tried to collaborate care with the licensee, due to lack of communication, the home health agency has to coordinate all care with R1. During an interview on February 15, 2024, at 1:00 p.m. the facility registered nurse (RN)-A stated two staff were scheduled at "certain times." Overnight there was only one staff member scheduled. RN-A stated R1 needed two staff for repositioning, bathing, and transfers. RN-A stated the licensee can complete wound care if there was a physician's order and caddy waiver coverage. RN-A stated R1 refused cares and went to wound care appointments on his own and wouldn't update the licensee on the provider's discussions. RN-A stated the licensee focused on patient centered care and provided care for R1 according to his service plan. The facility policy titled Treatment and Therapy Management dated April 3, 2023, indicated the RN was responsible for assessing and developing the treatment and/or therapy service plan for residents. The RN would provide coordination of care related to the treatment with other health care providers. The RN would prepare and individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses the type of service to	02310		

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02310	Continued From page 18 be provided, procedures for documenting, procedure for monitoring treatment to prevent possible complications or adverse reactions, identification of treatment or task delegated to unlicensed personnel and procedure for notifying the RN when a problem arises. Each staff member who administered a treatment was responsible for documenting in the clinical record and if a treatment was not administered as ordered staff would document the reason and any follow up procedures provided to meet the resident's needs. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag	