STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245247	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KITTSON MEMORIAL HEALTHCARE CENTER	1010 SOUTH BIRCH HALLOCK, MN 56728

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement physician orders [REDACTED]. This failure resulted in actual harm to R1 when the facility failed to conduct daily skin assessments as ordered resulting in the development of a stage 4 pressure ulcer. Although noncompliance was present at the time of the event, the facility implemented appropriate corrective action prior to the survey resulting in a finding of past-noncompliance for R1. Findings include: A Nursing Home Incident Report (NHIR) submitted 2/25/20, indicated R1 had sustained a [MEDICAL CONDITION] fibula and tibia on 1/19/20, which was evaluated in the emergency department (ED). Treatment consisted of placement of a splint to the left lower leg. R1 had returned to the facility with a hospital verbal order to not remove the splint. On 1/27/20, R1 was seen by the physician, and an X-ray identified no change to fracture therefore, order were given to continue with the splint. On 1/30/20, the staff notified the physician assistant (PA) regarding swelling to R1's left foot. The PA removed the splint and Ace wrap (elastic wrap) and examined R1's foot and leg. A reddened area was noted behind R1's left leg. The PA added additional padding to the back of R1's knee, and no further orders were received. On 2/5/20, the Ace wrap was removed, and a clean Ace wrap was applied. On 2/19/20, an X-ray indicated the fracture was healing. During physician rounds on 2/20/20, the Ace wrap and splint were removed and a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer was discovered, and no impact on R1's quality of life was noted. Care plan and orders were followed. The facilty's 5 day investigation form indicted the splint was discontinued and a boot was applied. Nursing order put into place were to check placement of the boot and skin condition every shift. R1's PA visit summary dated 1/30/20, indicated R1 exhibited severe puffiness with a fluid filled appearance at the top of the left foot from the toes to mid-foot, where the splint edge was. The edge of the splint was very tight on the foot and ankle bone. Ace wraps were removed times two, and the splint was released at the top of left leg and stretched back to loosen. Within two minutes, the swelling at the top of the foot started to decrease, and after five minutes there was minor puffiness noted. Pedal pulse (pulse noted on the top of the foot) was palpable, and the foot was warm and dry with good capillary refill. No open areas were noted. A one millimeter (mm) pink area was noted on the top of the left foot, medial side, without any sloughing of skin, and no raised area or indentation areas. A similar sized area was also noted on the posterior lower leg, lateral area at the bend of the knee. Cast padding was applied to the top of the foot and left lateral ankle. The splint was laid back over the leg and loosely wrapped with two Ace wraps to just below the knee, but not under where knee bends. The visit summary plan directed the nurses to check under R1's splint daily for skin exam, and then to rewrap. The swelling on the top of the left foot had gone down, and the physician had an order for [REDACTED]. R1's Physician Visit dated 2/20/20, indicated R1's splint was removed, and revealed a Stage 4 pressure ulcer with necrosis (death of cells or tissue) of muscle to left popliteal fossa (space behind the left knee). Dressing changes were implemented, and staff was to ensure R1 was seen by wound care staff. The splint was not to be reapplied, and a midcalf cushion boot was ordered to be worn for the left tibia/fibula fracture. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had severe cognitive impairment and [DIAGNOSES REDACTED]. R1 required total assistance of two staff for transfers, was unable to walk, and was at risk for pressure ulcers. R1's care plan dated 1/21/20, indicated R1 was at risk for developing pressure ulcers related to incontinence, immobility, and contractures to lower extremities. The care plan identified a superficial area on buttocks related to shearing, no other skin breakdown areas were identified. The care plan was revised on 2/20/20, identifying a pressure ulcer behind the left knee, and red area on top of left foot, with bi-weekly dressing change directives, and assessment of skin under boot every shift. However, the care plan lacked the directive related to the 1/30/20, PA order for the removal of the splint, and daily skin checks to be conducted under splint. R1's Medication Administration Record [REDACTED]. R1's Progress Notes reviewed from 1/30/20, through 2/20/20, lacked documentation reflecting daily skin monitoring had been conducted, as ordered. On 3/5/20, at 1:45 p.m. licensed practical nurse (LPN)-B confirmed R1's splint had not been removed, and skin assessments had not been completed prior to the identification of R1's pressure ulcer, because there were no orders to do so. -At 2:40 p.m. LPN-C stated following R1's fracture, she had been told the physician or NP would be following up on R1, and she was not to remove the splint. LPN-C stated R1's skin under the splint and behind the knee were not visible to assess without removing the splint. LPN-C stated removal of the splint and skin checks had not been implemented until after the physician had discovered the Stage 4 pressure ulcer. -At 3:12 p.m. during a telephone interview, PA-A confirmed she had visited R1 on 1/30/20, at which time the nursing staff had requested an evaluation of R1's left foot due to swelling. PA-A stated she had removed R1's splint, and noted two reddened areas on left lateral foot and behind the left knee which were approximately 1.0 mm in diameter, and were not open. PA-A stated she had written orders for the nurse to remove and check under R1's splint daily and to conduct a skin assessment, and then rewrap it. PA-A stated it was her expectation for nursing to implement the orders as written, as the ongoing monitoring of R1's skin would have identified the change in R1's skin condition thereby preventing R1's development of the Stage 4 pressure ulcer. -At 4:32 p.m. the director of nursing (DON) confirmed the physician identified R1 had developed a Stage 4 pressure ulcer on 2/20/20. The DON stated she reviewed R1's physician and PA visits and orders from the date of R1's fall resulting in fractures on 1/19/20, and on 2/20/20, she had discovered the order from the PA directing nursing staff to remove the splint and check R1's skin daily. The DON stated she discussed the order with the registered nurse (RN) unit coordinator, who confirmed she had not reviewed the summary and had missed the order. The DON stated the RN indicated the NP would add orders to her summaries that were not discussed during the NP visit, which resulted in the RN being unaware of the orders. The DON stated following a visit, the NP would dictate her visit, but verified the RN would have access to the dictated summary and any orders that same day. The DON confirmed the RN had neglected to review R1's PA visit summary, thereby missing the new order resulting in the daily skin assessments not being completed. The DON verified the daily skin checks had not been conducted from 1/30/20, until 2/20/20, when R1's Stage 4 pressure ulcer was identified by her physician. The DON stated it was her expectation for nursing to review provider summaries/orders, and implement changes as directed. The facility's Nurse Care Coordinator Job summary undated, indicated the care coordinator was responsible for transcribing and reviewing physician orders, and also assured that necessary arrangements were made, as ordered. The past non-compliance that began on 1/30/20, was reviewed to be corrected by 2/20/20, after the facility had implemented the following interventions: -Ensuring all residents had physician orders [REDACTED]. The Floor nurses were assigned to obtain, monitor, review, and follow up on all resident skin assessments and follow up if needed. -R1's physician orders [REDACTED]. R1's Care plan revised to reflect skin monitoring and dressing changes. -The identification of all potentially affected residents and reviewed all physician orders [REDACTED]. -Continued Quality Assurance: audits implemented to ensure enhanced system compliance. A risk management meeting was scheduled for 3/19/20. Weekly auditing in place and DON responsible for follow up. -Staff education was

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) provided. Verification of corrective action was confirmed by observations, interviews with a variety of staff including administration, and document review. Training and education was completed by 2/20/20, and ongoing audits conducted verified interventions had been implemented. Nursing staff were educated to the facility policy and revisions were made to include the on-going monitoring of resident skin assessment and follow-up to physician orders [REDACTED]. The facility incorporated the action plan into the facility wide quality assurance program.
F 0686 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement physician orders [REDACTED]. This failure resulted in an immediate jeopardy (IJ) situation for R1 due to the facility's failure to implement daily skin checks, which resulted in the development of a Stage 4 pressure ulcer. However, at the time of the investigation, it was determined the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance for R1. On [DATE], at 1:15 p.m. the facility administrator and director of nursing were notified of the facilities failure to prevent the development of pressures ulcers resulting in an IJ situation related to the development of a Stage 4 pressure ulcer for R1. The past non-compliance IJ began on 1/30/20, when the provider had identified pressure related areas under R1's left splint, and ordered daily splint removal and skin assessments which were not implemented until 2/20/20, after R1 had been identified with a Stage 4 pressure ulcer. Findings include: A Nursing Home Incident Report (NHIR) submitted 2/25/20, indicated R1 had sustained a [MEDICAL CONDITION] fibula and tibia on 1/19/20, which was evaluated in the emergency department (ED). Treatment consisted of placement of a splint to the left lower leg. R1 had returned to the facility with a hospital verbal order to not remove the splint. On 1/27/20, R1 was seen by the physician, and an X-ray identified no change to fracture therefore, order was given to continue with the splint. On 1/30/20, the staff notified the physician assistant (PA) regarding swelling to R1's left foot. The PA removed the splint and Ace wrap (elastic wrap) and examined R1's foot and leg. A reddened area was noted behind R1's left leg. The PA added additional padding to the back of R1's knee, and no further orders were received. On 2/5/20, the Ace wrap was removed, and a clean Ace wrap was applied. On 2/19/20, an X-ray indicated the fracture was healing. During physician rounds on 2/20/20, the Ace wrap and splint were removed and a Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer was discovered, and no impact on R1's quality of life was noted. Care plan and orders were followed. The facilty's 5 day investigation form indicted the splint was discontinued and a boot was applied. Nursing order was put into place were to check placement of the boot and skin condition every shift. R1's PA visit summary dated 1/30/20, indicated R1 exhibited severe puffiness with a fluid filled appearance at the top of the left foot from the toes to mid-foot, where the splint edge was. The edge of the splint was very tight on the foot and ankle bone. 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