MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Mount Olivet Rolling Acres
129 Mackenthun Lane
Norwood Young America, MN 55368
Carver County

Report#: HG503004

Date: August 1, 2016

Date of Visit: February 9, 2016
Time of Visit: 9:30 a.m. to 3:30 p.m.

By: Elizabeth Swan, RN, Special Investigator

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

☒ Facility Self Report ☐ Complaint

Allegation(s): It is alleged that a client was neglected when the client had multiple falls with injuries before facility staff transferred him/her to the emergency room. The client had two black eyes, multiple bruises, and was diagnosed with small brain bleed.

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

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☑ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)

☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☑ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

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

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

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

Based on a preponderance of evidence, neglect occurred when the nurse failed to assess the client when the client exhibited a change in behavior accompanied with multiple falls. The client had a subdural hemorrhage and was sent to the hospital. The client returned to the facility the same day with physician orders for monitoring and to have the client return to the hospital if further falls continued. Two days later, the client fell again and was transferred back to the hospital. The client was admitted to the hospital with another subdural hemorrhage. The client returned to the facility after a ten day hospital stay.

Client record review revealed the client exhibited changes for seven days that included weakness in the legs, stiffness of the torso/limbs and falls to the side or backwards. The client had approximately seven falls and hit his/her head on at least two witnessed occasions. The day before the client was transferred to the hospital, the client fell and hit his/her head on a door hinge. The client also had bruising of the right and left eye, nose, and abrasions on the cheek. The documentation indicated direct care staff notified the on call nurse of each occurrence. At least two nurses were aware of the repeated falls in this seven day period. The direct care staff were told not to send the client in to the emergency room as the nurses assumed the falls were behavior related. No onsite visits or assessments were done for the client by the nurses.

The client's record revealed no falls in the preceding quarterly review. The client's Support Services Assessment and Abuse Prevention Plan identified the client was at risk for medical treatment (no specifics identified) due to inability to report injury/illness. The intervention directed staff to visually observe for behavior/physical changes and report potential injury/illness to nursing and follow directives per protocol. The facility's Nursing Responsibilities protocol directed the licensed nurse to conduct an onsite status change assessments and triage as needed.

The hospital discharge record revealed the client was admitted for a subdural hemorrhage as a result of falls secondary to medication side effects/toxicity.

The physician was interviewed. The physician was not notified of the client's falls. The physician stated that at least, the client should be sent for an evaluation when a fall with head injury occurs.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility lacked policies and procedures that identified reasons for the licensed nurses to complete an onsite assessment of clients. The facility failed to ensure the licensed staff followed the nursing responsibilities guidelines that directed the nurses to do an onsite assessment and triage of any status change of the client.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) – Compliance Not Met
The requirements under Federal Regulations for ICF/IID (42 CFR, Part 483, subpart I) were not met.

Deficiencies are issued on form 2567: ☐ Yes ☐ No If no, specify: _____
(The 2567 will be available on the MDH website.)

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) – Compliance Not Met
The requirements under State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665) were not met.

State licensing orders were issued: ☐ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

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

State licensing orders were issued: ☐ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

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

The Investigation included the following:

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

☒ Medical Records
☐ Medication Administration Records
☒ Facility Incident Reports
☒ Care Guide
☒ Treatment Sheets
☐ Physician Progress Notes

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

Other pertinent medical records:

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

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☐ Resident/Family Council Minutes
☒ Personnel Records/Background Check, etc.
☒ Staff Time Sheets, Schedules, etc.
☐ Facility In-service Records
☒ Facility Internal Investigation Reports
☒ Facility Policies and Procedures
☐ Call Light Audits
☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: facility self-report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

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

Did you interview the resident(s) identified in allegation: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: 0

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 8

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

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

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

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

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☒ Safety Issues	☒ Facility Tour

☐ Infection Control ☒ Cleanliness ☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☐ Other: _____

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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification
The Office of Ombudsman for Mental Health and Developmental Disabilities
Norwood Young America City Police Department
Carver County Attorney
Norwood Young America City Attorney
The Office of the Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G503	A. BUILDING _____ B. WING _____	C 03/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #HG503004. As a result, the following deficiency is issued.	W 000		
W 339	483.460(c)(4) NURSING SERVICES Nursing services must include other nursing care as prescribed by the physician or as identified by client needs. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing services completed an assessment when one of one (C1) client had falls with head injuries over a four day period. The client was diagnosed with a subdural hematoma when finally transferred and evaluated for medical treatment. The findings include: The medical record was reviewed and revealed Client #1's (C1)'s diagnoses included developmental disability, intermittent explosive disorder, impulse control disorder and hypothyroid. The Support Services Assessment and Abuse Prevention Plan dated October 23, 2015, identified C1 at risk for medical treatment due to inability to report injury/illness. The plan directed staff to visually observe for behavior/physical changes and report potential injury/illness to Mount Olivet Rolling Acres nursing and follow directives per protocol. On February 18, 2016, the facility's Nursing Responsibilities protocol dated 12/15, was received and reviewed. The protocol directed the licensed nurse to conduct an onsite status change assessment and	W 339	W 339 Procedure for On Call Nursing (On call Nursing week is a Wed - Wed): • Nurse is expected to be available via phone at all times (return calls within 5-10 mins or as soon as reasonably possible) • Duties that are expected would include triage and onsite assessments as needed as well as receiving and processing accident reports and medication errors • Nurses are not expected to staff houses or take clients to Urgent Care/ER (there may be exceptions in an emergency situation, especially during the overnight but these are rare) • During the week, houses are to be calling their primary nurse first prior to calling the on call nurse.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Chief Operating Officer — (X6) DATE: 4/13/16

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.

Revised on 4/26/16

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W 339	Continued From page 1 triage as needed. On further review of the client's medical record in addition to review of the Mount Olivet Rolling Acres Client Accident/Injury Forms the following was revealed: On December 1, 2015, at 8:40 a.m., the client fell to the floor when turning around landing on his/her right side. The documentation indicated staff noted the client to lean back when walking after the fall. On December 3, 2015, at 4:45 p.m. the client was noted to fall to the floor when turning around landing on his/her right side. The client complained of a pain in the elbow. Record documentation also identified the client had an unwitnessed fall in which the client hit his/her head that caused bleeding (location not identified). The documentation identified registered nurse (RN)F was notified, and directed staff to administer ibuprofen 400 milligrams (mg) for the head injury. On December 6, 2015, the client's record and facility's accident/injury reports identified the client had "dropped" four times in the morning in which the client hit his/her head on two occasions which resulted in visible bruising of the left and right eye, scratches on the right cheek, bruised nose, and cut to the top of his/her head. At this point the client refused and staff were unable to get C1 off the floor. RN/F was notified of all incidents including that the client was on the floor. RN/F directed staff to administer Valium (anxiolytic) 5 mg for agitation. The record documentation reveals C1 remained on the floor until December 7, 2015, when the client was transported to the	W 339	• If assistance and or consult on the weekend is needed by the on call nurse, he or she is expected to contact the Health Services/Nursing Director. On Call nurse may also try calling site primary nurse for consultation and or assistance • If nurse is unable to work the scheduled on call week, the nurse is expected to switch with another nurse and notify Health Services/ Nursing Director and the Health Services Manager. Retraining with Mount Olivet Rolling Acres nurses was conducted by the Director of Nursing. Retraining includes: review of the Maltreatment Prevention Plan, review of the ICF/ IDD Client Bill of Rights, and review of the procedure for on call nursing. Nursing staff was trained on the practice of having clients with a suspected head injury be evaluated by urgent care/ER.	

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W 339	Continued From page 2 emergency room and evaluated at 8:30 a.m. CT scans of the client's head, facial bones spine and shoulder revealed the client had sustained a subdural hemorrhage. On February 9, 2016, at 1:00 p.m., direct support professional (DSP)A was interviewed. DSP/A worked with C1 and stated on rare occasions the client would go to his/her knees when there was a change in footing, such as going from concrete to gravel. DSP/A stated this was referred to "dropping" and eventually the client would get up and walk to the destination. DSP/A stated the behavior of C1 on December 6, 2015, was different. DSP/A stated the client would shake, stiffen up and fall straight back. DSP/A provided blankets and pillows for C1 on December 6, 2015, as staff could not get the client up from the floor. DSP/A stated RN/F was called several times about C1. On February 9, 2016, at 1:45 p.m. DSP/C was interviewed. DSP/C stated the falls that C1 had were not the same as the "dropping" episodes the client would sometimes have when there was change in surface. DSP/C stated when the client "dropped" s/he would slowly lower self to knees or sit on the ground. The episodes in December were different as the client would stiffen up and fall to the ground. DSP/C notified RN/F of each fall and followed RN/F's directives which included administration of Valium 5 mg for agitation. On February 9, 2016, at 2:25 p.m. the program director (PD) was interviewed. The PD stated when s/he came to work in the a.m. of December 7, 2015, s/he immediately summoned emergency transport for a medical evaluation. The PD verified that C1 had a history of "dropping" and	W 339	Retraining with Mount Olivet Rolling Acres residential staff was conducted by the Training Coordinator on 1/8/2016 and 1/11/2016. Training regarding C1's dropping/falling and knowing the differences between medical falling and behavioral dropping occurred with residential staff. Please see attached sign in sheets for the dates listed above and also a sign off sheet for those who read the Mackenthun Training- C1 Drop/Fall information that is also attached. On 4/6/2016, Director of Nursing provided training to residential staff regarding head injuries. This training consisted of teaching staff how to identify and monitor symptoms of a head injury.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 339	Continued From page 3 that it occurred when there was a change in environmental surface. The PD stated this behavior was infrequent and that s/he was not aware of any injuries sustained when C1 did this. On review of C1's annual reviews dated October 23, 2015, which included the Health Care Plan, Individual Program Plan and Individual Behavior Plan, there was no mention of "dropping" episodes as being an interference with C1's daily activities. The PD verified the "dropping" episodes were infrequent. On further review of documents the PD verified the most recent accident/injury report for C1 prior to the December occurrences was a client to client altercation that happened on September 23, 2015. On February 16, 2016, at 2:10 p.m. RN/F was interviewed. RN/F verified staff had notified him/her of the frequent "dropping" episodes on December 6, 2015, and that s/he determined it was behavioral and not medical without going to the facility and doing an onsite assessment of C1. RN/F stated an onsite visit would be warranted if there was a medical emergency. RN/F verified awareness of C1's head injuries and did not feel an onsite visit was warranted. On February 16, 2016 at 3:30 p.m. the director of nursing (DON) for the facility was interviewed. The DON verified the facility had 24 hour on call nursing and part of these responsibilities included onsite visits when a client exhibited a change in status. The DON stated an onsite visit by the RN should have been done for C1's change in status. On March 2, 2016, at 1:06 p.m. the physician was interviewed. The physician verified there was no notification of the changes or falls that C1 exhibited. The physician stated a medical	W 339	W339 Systemic changes to prevent issues such as this are covered in the retraining that was provided to nursing and residential staff. The Director of Nursing will monitor the procedure for on call nursing to ensure that adequate nursing services are being provided. The Program Supervisor will provide ongoing training as needed to new staff at the home regarding C1's dropping/ falling concerns. Correction completed on April 12, 2016.	

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W 339	Continued From page 4 evaluation should be done whenever a head injury is involved, and that the directives to administer Ibuprofen and Valium would not be recommended without a medical evaluation for a head injury.	W 339		

Minnesota Department of Health

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the Initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. A complaint investigation was conducted to investigate case #HG503004. As a result, the following correction order is issued.	5 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Chief Operating Officer

(X6) DATE: 4/13/16

Revised on 4/26/16

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5 000	Continued From page 1	5 000	out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
5 560	MN Rule 4665.5400 A. EMERGENCY AND UNUSUAL OCCURRENCE. In case of accident: A. appropriate measures for the care and safety of the resident shall be undertaken; and This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing services completed an assessment when one of one (C1) client had falls with head injuries over a four day period. The client was diagnosed with a subdural hematoma when finally transferred and evaluated for medical treatment.	5 560	Retraining with Mount Olivet Rolling Acres residential staff was conducted by the Training Coordinator on 1/8/2016 and 1/11/2016. Training regarding C1's dropping/falling and knowing the differences between medical falling and behavioral dropping occurred with residential staff. Please see attached sign in sheets for the dates listed above and also a sign off sheet for those who read the Mackenthun Training- C1 Drop/Fall information that is also attached.	

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MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

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5 560	Continued From page 2 The findings include: The medical record was reviewed and revealed Client #1's (C1)'s diagnoses included developmental disability, intermittent explosive disorder, impulse control disorder and hypothyroid. The Support Services Assessment and Abuse Prevention Plan dated October 23, 2015, identified C1 at risk for medical treatment due to inability to report injury/illness. The plan directed staff to visually observe for behavior/physical changes and report potential injury/illness to Mount Olivet Rolling Acres nursing and follow directives per protocol. On February 18, 2016, the facility's Nursing Responsibilities protocol dated 12/15, was received and reviewed. The protocol directed the licensed nurse to conduct an onsite status change assessment and triage as needed. On further review of the client's medical record in addition to review of the Mount Olivet Rolling Acres Client Accident/Injury Forms the following was revealed: On December 1, 2015, at 8:40 a.m., the client fell to the floor when turning around landing on his/her right side. The documentation indicated staff noted the client to lean back when walking after the fall. On December 3, 2015, at 4:45 p.m. the client was noted to fall to the floor when turning around landing on his/her right side. The client complained of a pain in the elbow. Record documentation also identified the client had an unwitnessed fall in which the client hit his/her head that caused bleeding (location not identified). The documentation identified registered nurse (RN)F was notified, and directed	5 560	On 4/6/2016, Director of Nursing provided training to residential staff regarding head injuries. This training consisted of teaching staff how to identify and monitor symptoms of a head injury. See attached sign in sheet for 4.6.16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21000	A. BUILDING: _____ B. WING _____	C 03/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

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5 560	Continued From page 3 staff to administer ibuprofen 400 milligrams (mg) for the head injury. On December 6, 2015, the client's record and facility's accident/injury reports identified the client had "dropped" four times in the morning in which the client hit his/her head on two occasions which resulted in visible bruising of the left and right eye, scratches on the right cheek, bruised nose, and cut to the top of his/her head. At this point the client refused and staff were unable to get C1 off the floor. RN/F was notified of all incidents including that the client was on the floor. RN/F directed staff to administer Valium (anxiolytic) 5 mg for agitation. The record documentation reveals C1 remained on the floor until December 7, 2015, when the client was transported to the emergency room and evaluated at 8:30 a.m. CT scans of the client's head, facial bones spine and shoulder revealed the client had sustained a subdural hemorrhage. On February 9, 2016, at 1:00 p.m., direct support professional (DSP)A was interviewed. DSP/A worked with C1 and stated on rare occasions the client would go to his/her knees when there was a change in footing, such as going from concrete to gravel. DSP/A stated this was referred to "dropping" and eventually the client would get up and walk to the destination. DSP/A stated the behavior of C1 on December 6, 2015, was different. DSP/A stated the client would shake, stiffen up and fall straight back. DSP/A provided blankets and pillows for C1 on December 6, 2015, as staff could not get the client up from the floor. DSP/A stated RN/F was called several times about C1. On February 9, 2016, at 1:45 p.m. DSP/C was interviewed. DSP/C stated the falls that C1 had	5 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21000	A. BUILDING: _____ B. WING _____	C 03/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

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5 560	Continued From page 4 were not the same as the "dropping" episodes the client would sometimes have when there was change in surface. DSP/C stated when the client "dropped" s/he would slowly lower self to knees or sit on the ground. The episodes in December were different as the client would stiffen up and fall to the ground. DSP/C notified RN/F of each fall and followed RN/F's directives which included administration of Valium 5 mg for agitation. On February 9, 2016, at 2:25 p.m. the program director (PD) was interviewed. The PD stated when s/he came to work in the a.m. of December 7, 2015, s/he immediately summoned emergency transport for a medical evaluation. The PD verified that C1 had a history of "dropping" and that it occurred when there was a change in environmental surface. The PD stated this behavior was infrequent and that s/he was not aware of any injuries sustained when C1 did this. On review of C1's annual reviews dated October 23, 2015, which included the Health Care Plan, Individual Program Plan and Individual Behavior Plan, there was no mention of "dropping" episodes as being an interference with C1's daily activities. The PD verified the "dropping" episodes were infrequent. On further review of documents the PD verified the most recent accident/injury report for C1 prior to the December occurrences was a client to client altercation that happened on September 23, 2015. On February 16, 2016, at 2:10 p.m. RN/F was interviewed. RN/F verified staff had notified him/her of the frequent "dropping" episodes on December 6, 2015, and that s/he determined it was behavioral and not medical without going to the facility and doing an onsite assessment of C1. RN/F stated an onsite visit would be warranted if there was a medical emergency. RN/F verified	5 560		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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5 560	Continued From page 5 awareness of C1's head injuries and did not feel an onsite visit was warranted. On February 16, 2016 at 3:30 p.m. the director of nursing (DON) for the facility was interviewed. The DON verified the facility had 24 hour on call nursing and part of these responsibilities included onsite visits when a client exhibited a change in status. The DON stated an onsite visit by the RN should have been done for C1's change in status. On March 2, 2016, at 1:06 p.m. the physician was interviewed. The physician verified there was no notification of the changes or falls that C1 exhibited. The physician stated a medical evaluation should be done whenever a head injury is involved, and that the directives to administer Ibuprofen and Valium would not be recommended without a medical evaluation for a head injury. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 560		
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited	5 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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5 700	Continued From page 6 period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure nursing services completed an assessment when one of one (C1) client had falls with head injuries over a four day period. The client was diagnosed with a subdural hematoma when finally transferred and evaluated for medical treatment. The findings include: The medical record was reviewed and revealed Client #1's (C1)'s diagnoses included developmental disability, intermittent explosive disorder, impulse control disorder and hypothyroid. The Support Services Assessment and Abuse Prevention Plan dated October 23, 2015, identified C1 at risk for medical treatment due to inability to report injury/illness. The plan directed staff to visually observe for behavior/physical changes and report potential injury/illness to Mount Olivet Rolling Acres nursing and follow directives per protocol. On February 18, 2016, the facility's Nursing Responsibilities protocol dated 12/15, was received and reviewed. The protocol directed the licensed nurse to conduct an onsite status change assessment and triage as needed. On further review of the client's medical record in addition to review of the Mount Olivet Rolling Acres Client Accident/Injury Forms the following was revealed:	5 700	Retraining with Mount Olivet Rolling Acres nurses was conducted by the Director of Nursing. Retraining includes: review of the Maltreatment Prevention Plan, review of the ICF/IDD Client Bill of Rights, and review of the procedure for on call nursing. Nursing staff was trained on the practice of having clients with a suspected head injury be evaluated by urgent care/ER. Retraining with Mount Olivet Rolling Acres residential staff was conducted by the Training Coordinator on 1/8/2016 and 1/11/2016. Training regarding C1's dropping/falling and knowing the differences between medical falling and behavioral dropping occurred with residential staff. Please see attached sign in sheets for the dates listed above and also a sign off sheet for those who read the Mackenthun Training- C1 Drop/Fall information that is also attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21000	A. BUILDING: _____ B. WING _____	C 03/02/2016

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5 700	Continued From page 7 On December 1, 2015, at 8:40 a.m., the client fell to the floor when turning around landing on his/her right side. The documentation indicated staff noted the client to lean back when walking after the fall. On December 3, 2015, at 4:45 p.m. the client was noted to fall to the floor when turning around landing on his/her right side. The client complained of a pain in the elbow. Record documentation also identified the client had an unwitnessed fall in which the client hit his/her head that caused bleeding (location not identified). The documentation identified registered nurse (RN)F was notified, and directed staff to administer ibuprofen 400 milligrams (mg) for the head injury. On December 6, 2015, the client's record and facility's accident/injury reports identified the client had "dropped" four times in the morning in which the client hit his/her head on two occasions which resulted in visible bruising of the left and right eye, scratches on the right cheek, bruised nose, and cut to the top of his/her head. At this point the client refused and staff were unable to get C1 off the floor. RN/F was notified of all incidents including that the client was on the floor. RN/F directed staff to administer Valium (anxiolytic) 5 mg for agitation. The record documentation reveals C1 remained on the floor until December 7, 2015, when the client was transported to the emergency room and evaluated at 8:30 a.m. CT scans of the client's head, facial bones spine and shoulder revealed the client had sustained a subdural hemorrhage. On February 9, 2016, at 1:00 p.m., direct support professional (DSP)A was interviewed. DSP/A	5 700	On 4/6/2016, Director of Nursing provided training to residential staff regarding head injuries. This training consisted of teaching staff how to identify and monitor symptoms of a head injury. See attached sign in sheet for 4/6/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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5 700	Continued From page 8 worked with C1 and stated on rare occasions the client would go to his/her knees when there was a change in footing, such as going from concrete to gravel. DSP/A stated this was referred to "dropping" and eventually the client would get up and walk to the destination. DSP/A stated the behavior of C1 on December 6, 2015, was different. DSP/A stated the client would shake, stiffen up and fall straight back. DSP/A provided blankets and pillows for C1 on December 6, 2015, as staff could not get the client up from the floor. DSP/A stated RN/F was called several times about C1. On February 9, 2016, at 1:45 p.m. DSP/C was interviewed. DSP/C stated the falls that C1 had were not the same as the "dropping" episodes the client would sometimes have when there was change in surface. DSP/C stated when the client "dropped" s/he would slowly lower self to knees or sit on the ground. The episodes in December were different as the client would stiffen up and fall to the ground. DSP/C notified RN/F of each fall and followed RN/F's directives which included administration of Valium 5 mg for agitation. On February 9, 2016, at 2:25 p.m. the program director (PD) was interviewed. The PD stated when s/he came to work in the a.m. of December 7, 2015, s/he immediately summoned emergency transport for a medical evaluation. The PD verified that C1 had a history of "dropping" and that it occurred when there was a change in environmental surface. The PD stated this behavior was infrequent and that s/he was not aware of any injuries sustained when C1 did this. On review of C1's annual reviews dated October 23, 2015, which included the Health Care Plan, Individual Program Plan and Individual Behavior Plan, there was no mention of "dropping"	5 700		

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5 700	Continued From page 9 episodes as being an interference with C1's daily activities. The PD verified the "dropping" episodes were infrequent. On further review of documents the PD verified the most recent accident/injury report for C1 prior to the December occurrences was a client to client altercation that happened on September 23, 2015. On February 16, 2016, at 2:10 p.m. RN/F was interviewed. RN/F verified staff had notified him/her of the frequent "dropping" episodes on December 6, 2015, and that s/he determined it was behavioral and not medical without going to the facility and doing an onsite assessment of C1. RN/F stated an onsite visit would be warranted if there was a medical emergency. RN/F verified awareness of C1's head injuries and did not feel an onsite visit was warranted. On February 16, 2016 at 3:30 p.m. the director of nursing (DON) for the facility was interviewed. The DON verified the facility had 24 hour on call nursing and part of these responsibilities included onsite visits when a client exhibited a change in status. The DON stated an onsite visit by the RN should have been done for C1's change in status. On March 2, 2016, at 1:06 p.m. the physician was interviewed. The physician verified there was no notification of the changes or falls that C1 exhibited. The physician stated a medical evaluation should be done whenever a head injury is involved, and that the directives to administer Ibuprofen and Valium would not be recommended without a medical evaluation for a head injury. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 700		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
24G503	A. Building B. Wing	5/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix W0339 Reg. # 483.460(c)(4) LSC	Correction Completed 05/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
21000 Y1	A. Building B. Wing Y2	5/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVET ROLLING ACRES	129 MACKENTHUN LANE NORWOOD YOUNG AMERIC, MN 55368

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 50560 Reg. # MN Rule 4665.5400 A. LSC	Correction Completed 05/06/2016	ID Prefix 50700 Reg. # MN Statute 144.651 Subd. 14. LSC	Correction Completed 05/06/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: N41Y12

STATE FORM: REVISIT REPORT (11/06)