Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21672013M
Compliance #: HL21672014C

Date Concluded: March 9, 2021

Name, Address, and County of Licensee Investigated:
New Perspective Cloquet & Barnum
702 Horizon Circle
Cloquet, MN 55720
Carlton County

Name, Address, and County of Housing with Services location:
New Perspective Cloquet Barnum
705 Horizon Circle
Cloquet, MN 55720
Carlton County

Facility Type: Home Care Provider

Investigator's Name: Angela Vatalaro, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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

Allegation(s): It is alleged: The alleged perpetrator (AP) neglected the client when she failed to provide a two-staff assisted transfer as indicated in the client's service plan. The client fell and sustained facial contusion.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the AP were responsible for the maltreatment. The facility failed to provide supplemental staff orientation to the AP (who was a contracted agency staff) before she started to provide care to clients. The AP provided a one-staff assisted transfer when the client's service plan indicated she required two-staff assistance. The client fell sustained a facial contusion, closed head injury, and the clients facial CT-scan indicated a small-depressed fracture.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and the client's family. The investigation included review of the client's medical record, emergency room record, incident reports, internal investigations, policy and procedures

related to maltreatment, nursing assessments, change in condition, service plans, fall prevention, and team member orientation. The investigation included a review of the AP's employee file and training records. Finally, the investigator observed other staff assisted client transfers.

The client's diagnoses included Alzheimer's. The client's signed service plan indicated the client required assistance with medication administration, dressing, grooming, bathing, bed mobility, two-staff assist using a gait belt for transfers, one-staff assist for mobility using a gait belt and walker, and safety checks. The client's nursing assessment indicated the client was forgetful, had cognitive impairment, and did not have a history of falls.

One morning, two unlicensed personnel (ULP) assisted the client to sit on the couch. The client was not far enough back when attempting to sit. The two ULP's lowered the client to the floor. The client complained of right hip pain and sustained a skin tear on top of her right hand. The medical provider ordered X-rays of the client's hip and pelvis. The X-rays showed no acute fracture. The facilities investigation records of the incident indicated to continue with two staff assistance for transfers.

Approximately three weeks later, the AP transferred the client using a gait belt and walker without another staff member present. The client took one-step, knees buckled, and she fell into her walker towards the floor hitting the right side of her face on the floor. The AP was unable to assist the client with a safe fall. The client's right eye was black and blue, swollen, and she was unable to open her eye. In addition, the client sustained a skin tear on top of her right eyebrow and scratches to the right side of her face. The facility staff provided ice to the right eye. Two days later, the client's condition remained the same and the client transferred to the emergency room for evaluation.

A review client's emergency room records indicated the client diagnosed with a facial contusion and closed head injury. The client's CT scan of her facial bones indicated a small-depressed fracture. The same records indicated the client discharged back to the facility with orders to apply ice to the forehead.

A review of the facility's internal investigation indicated the AP applied a gait belt and provided the client her walker to go the bathroom. The client took one-step, knees buckled, and she fell into her walker towards the floor hitting the right side of her face on the floor. The AP stated she did not have a second person in the room to assist with the transfer and that she did not know how to use the Point of Care (POC, electronic record system) iPhone to reference the client's service plan. The AP did not review the client's printed service plan before providing care that indicated the client required a two-staff assist for transfers. During a review of the AP's personnel file, the facility identified that the AP did not receive the supplemental agency staff orientation prior to working with clients. This training included POC iPhone use.

A review of the AP's training records indicated the AP worked at the facility and provided care to clients for approximately three weeks before receiving the orientation.

During an interview, a registered nurse (RN-D) stated she conducted an internal investigation and discovered the AP did not have a second staff present to assist with the client's transfer. RN-D stated the AP was a contracted agency staff. She stated the process with training agency staff included an orientation on each client and the services required. RN-D stated she discovered the AP did not receive the orientation before her first assignment however, she stated the AP did have a shadow day. She added the AP was aware of the client's printed service plans and where to locate them. RN-D stated the facility prints service plans as a backup in case the electronic system failed. RN-D stated the AP received the orientation training two days after the client fell and sustained injury. RN-D stated it is an expectation that agency staff receive orientation before providing care to clients and that staff provide services as indicated on the service plan. RN-D stated the AP no longer works at the facility.

During an interview, RN-E stated after the first fall, if she felt a change was necessary she would have recommended one. RN-E stated she conducted the post fall assessment and felt the intervention was appropriate. RN-E stated the client had a second fall approximately three weeks later, when provided a one-staff assist to transfer. She stated the client's service plan indicated a two-staff assist. RN-E stated after the second fall she provided education to all staff about following clients care plans.

The AP did not respond to a subpoena to interview.

In conclusion, neglect was substantiated.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

(5) an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that results in injury or harm, which reasonably requires the care of a physician, and:

(i) the necessary care is provided in a timely fashion as dictated by the condition of the vulnerable adult;
(ii) if after receiving care, the health status of the vulnerable adult can be reasonably expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;
(iii) the error is not part of a pattern of errors by the individual;
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: No, unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, did not respond to subpoena.

Action taken by facility: The facility nurse assessed the client, educated staff on fall interventions, and sent the client into the emergency room for evaluation. The facility conducted an internal investigation and provided the AP orientation after discovery that it was not completed.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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.

cc:

The Office of Ombudsman for Long Term Care
Carlton County Attorney
Cloquet City Attorney

Cloquet Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21672	A. BUILDING: _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BARNUM	702 HORIZON CIRCLE CLOQUET, MN 55720

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On January 19, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL21672012C/#HL21672011M and #HL21672014C/#HL21672013M. At the time of the survey, there were # 62 clients receiving services under the comprehensive license. The following correction order is issued for #HL21672012C/#HL21672011M, tag identification 0860. The following correction orders are issued for #HL21672014C/#HL21672013M, tag identification 1180, 0325.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who	0 325		

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0 325	Continued From page 1 receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure 1 of 2 clients reviewed (C2) was free from maltreatment. C2 was neglected. Findings include: On March 9, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person and the facility were responsible for the maltreatment, in connection with an incident which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	A plan of correction is not required for tag 325, please refer to the public maltreatment report for details.	
0 860 SS=D	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8.Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be	0 860		

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0 860	Continued From page 2 conducted by the appropriate health professional. This initial assessment must be completed within five days after the date that home care services are first provided. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after the date that home care services are first provided. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive re-assessment for 1 of 4 clients (C1) reviewed when health conditions changed. C1 hospitalized, returned to the facility and admitted to hospice eight days later. The practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death;) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). C1's medical record was reviewed. C1's	0 860		

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0 860	Continued From page 3 diagnoses included dementia and hypomagnesemia (low magnesium levels). A review of C1's hospital records dated August 3, 2020, indicated C1 hospitalized for an acute kidney injury and discharged back to the facility on August 3, 2020. C1's nursing assessment dated August 3, 2020, indicated C1 was forgetful, had cognitive impairment, and a history of falls. C1's signed service plan dated August 4, 2020, included assistance with medication administration, dressing, grooming, bathing, ostomy and catheter care, bed mobility, repositioning, assist of one staff using a gait belt and walker for transfers and ambulation. The same document also indicated two-hour safety checks. C1's progress notes dated August 19, 2020, at 12:27 p.m., indicated C1 had a fall, hit his head and transferred to the emergency room for evaluation. C1's progress notes dated August 19, 2020, at 6:18 p.m., indicated C1's CT scan showed no abnormalities and C1 returned to the facility. A review of C1's emergency room record dated August 19, 2020, indicated discharge orders to observe, continue same medications, and assist with ambulation (walking). C1's progress notes dated August 20, 2020, at 12:28 p.m., indicated the licensee requested orders for a transfer bar for C1's bed to assist with transferring.	0 860		

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0 860	Continued From page 4 C1's progress notes dated August 25, 2020, at 1:24 a.m., indicated C1 was agitated, aggressive, and removed his catheter. The same progress notes indicated C1 transferred to the emergency room. A review of C1's emergency room records dated August 25, 2020, indicated C1 diagnosed with agitation due to dementia. The same records also indicated C1 did not have apparent issues with his catheter or acute issues, and discharged with orders to continue care at the facility. C1's progress notes dated August 25, 2020, at 6:56 a.m., indicated C1 returned to the facility. C1's progress notes dated August 25, 2020, at 8:37 a.m., indicated C1 diagnosed with agitation due to dementia. The same progress notes also indicated C1 was more confused, agitated, swearing, gritting his teeth, and shaking hands in anger. C1's progress notes dated August 25, 2020, at 10:59 a.m., indicated orders to collect a urinalysis and urine culture and to monitor blood pressure and pulse. C1's progress notes dated August 26, 2020, indicated C1 was unresponsive and hands clenched tight. C1 transferred to the emergency room. A review of C1's emergency room records dated August 26, 2020, indicated C1 diagnosed with confusion, dementia, and dehydration. In addition, C1 was prescribed ciprofloxacin (antibiotic). C1's progress notes dated August 26, 2020, at 10:19 p.m., indicated C1 returned to the facility	0 860		

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0 860	Continued From page 5 and appeared more disoriented and confused than baseline. C1's progress notes dated August 27, 2020, at 1:25 a.m., indicated C1 was agitated and was pulling at his colostomy bag and catheter. At 9:44 a.m., the licensee encouraged fluid intake for C1. At 12:22 p.m., C1 walked to lunch and was about to "pass out" when facility staff assisted him to sit in a chair. C1's blood pressure measured 78/46. The same progress notes also indicated C1 had juice and staff encouraged fluid intake. At 4:05 p.m., C1's blood pressure measured 94/31 and staff encouraged fluid intake. At 5:26 p.m., C1's medical provider discontinued C1's Lisinopril (medication to treat high blood pressure) and ordered Mag Ox (medication to treat low magnesium levels) C1's progress notes dated August 28, 2020, at 2:01 p.m., indicated staff assisted C1 from dining chair to sunroom when C1 lost his balance and landed on his buttocks. The same document indicated C1 hit his right elbow causing a wound. At 4:06 p.m., the nurse updated the medical provider regarding the right elbow wound and requested surgical glue to close the wound. At 5:24 p.m., the nurse could not obtain surgical glue from the pharmacy. The same progress notes indicated C1 transferred to the emergency room. A review of C1's emergency room records dated August 28, 2020 indicated C1 diagnosed with a right elbow laceration and received sutures (stitches). C1's progress notes dated August 29, 2020, 6:06 a.m., indicated C1 had a fall and had a large bump to his head. The same progress notes	0 860		

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0 860	Continued From page 6 indicated C1 transferred to the emergency room. At 1:33 p.m., C1 admitted to the hospital for hematoma and low magnesium levels. C1's progress notes dated September 9, 2020, at 6:57 p.m., indicated C1 returned from the hospital stay. C1's medical record did not include an assessment after C1's return to the facility after hospitalization. C1's progress notes dated September 13, 2020, at 9:59 a.m., indicated C1 had increased weakness and shakiness when attempting to stand. C1's progress notes dated September 14, 2020, at 1:32 p.m., indicated C1 self-transferred and had a fall without injury. C1's progress notes dated September 15, 2020, at 9:46 a.m., indicated C1 was difficult to assist with transferring and dressing. At 12:23 p.m., C1's primary medical provider spoke with C1's family about a hospice evaluation. C1's progress notes dated September 16, 2020, at 6:35 p.m., indicated C1 had a fall and hit his head on the recliner. C1's progress notes dated September 17, 2020, at 3:32 p.m., indicated C1 admitted to hospice. C1's medical record did not include an assessment after C1's admission to hospice services. During an interview on January 28, 2021, at 9:18 a.m., registered nurse (RN-D), who identified as	0 860		

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0 860	Continued From page 7 the district director of clinical services stated that with C1's multiple transfers to the emergency room, ongoing falls, a hospitalization, and admission to hospice, indicated a comprehensive reassessment was required. During an interview on January 28, 2021, at 1:00 p.m., RN-E stated after C1's hospitalization and admission to hospice services a comprehensive reassessment was not conducted. RN-E stated a comprehensive reassessment was indicated. RN-E stated after each fall a post-fall assessment was completed, C1's medical provider updated, and new interventions implemented. The licensee-provided policy titled "Assessments," dated January 15, 2021, indicated the registered nurse would reassess after changes in needs of a resident. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 860		
01180 SS=G	144A.4796, Subd. 4 Orientation to Client Subd. 4.Orientation to client. Staff providing home care services must be oriented specifically to each individual client and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure 1 of 2 unlicensed personnel (ULP-F) was oriented to each individual client. ULP-F was a contracted agency staff. The licensee did not complete ULP-F's	01180		

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01180	Continued From page 8 supplemental staff orientation training before ULP-F provided cares 1 of 4 clients (C2) reviewed. C2's service plan indicated she required a two-staff assist for transfers. ULP-F provided a one-staff assist. C2 fell and sustained a facial contusion, closed head injury, and C2's facial CT scan indicated a small-depressed fracture. The practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C2's medical record was reviewed. C2's diagnoses included Alzheimer's disease. C2's signed service plan dated August 24, 2020, included assistance with medication administration, dressing, grooming, bathing, bed mobility, two-staff using a gait belt for transfers, one-staff assist for mobility using a gait belt and walker, and safety checks. C2's nursing assessment dated August 26, 2020, indicated C2 was forgetful, had cognitive impairment, and did not have a history of falls. C2's incident report dated September 6, 2020, at 9:19 a.m., indicated two ULP assisted C2 to sit on the couch. C2 was not back far enough when attempting to sit and the two ULP's lowered C2 to the floor. At 9:46 a.m., C2 complained of right hip pain. At 9:57 a.m., indicated staff observed a skin	01180		

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01180	Continued From page 9 tear on top of C2's right hand. A review of the licensee's internal investigation dated September 6, 2020, indicated post fall interventions that included staff education to ensure the back of C2's legs touched the seat before sitting. The same document also indicated to continue two-staff assist for transfers. C2's progress notes dated September 7, 2020, at 3:13 p.m. indicated C1 had right hip pain, ambulated slowly, and was able to bear weight. C2's progress notes dated September 9, 2020, at 4:13 p.m., indicated C2's medical provider ordered hip and pelvic X-rays. C2's progress notes dated September 10, 2020, at 10:51 a.m., indicated C2's X-rays showed no acute fractures. C2's progress notes dated September 26, 2020, at 10:08 p.m., indicated C2 had a witnessed fall in her room. C2 hit her right eye on the floor. C2's progress notes dated September 27, 2020, at 10:40 a.m., indicated C2's right eye was black and blue, swollen, and she was unable open her right eye. The same progress notes also indicated a skin tear on top of her eyebrow, scratches to the right side of her face, and staff applied ice to the right eye. C2's post fall evaluation dated September 27, 2020, indicated that on September 26, 2020, one-staff assisted C2 with a transfer and C2 fell. The same document indicated the ULP was unable to assist C2 with a safe fall. C2 fell hit her head and sustained an abrasion, skin tear, right eye and facial bruising.	01180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21672	A. BUILDING: _____ B. WING _____	C 01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - CLOQUET & BARNUM	702 HORIZON CIRCLE CLOQUET, MN 55720

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01180	Continued From page 10 C2's progress notes dated September 28, 2020, at 3:21 p.m., indicated C2's right side of face was swollen, black and blue, and she was unable to open her eye. The same document indicated C2 transferred to the emergency room for evaluation. A review of C2's emergency room records dated September 28, 2020, indicated C2 diagnosed with a facial contusion and closed head injury. C2's CT scan of her facial bones indicated a small-depressed fracture. The same records indicated discharge back to the facility with orders to apply ice to the forehead. A review of the licensee's internal investigation indicated ULP-F applied a gait belt and provided C2 her walker to go the bathroom. C2 took one step, knees buckled, and she fell into her walker towards the floor hitting the right side of her face on the floor. The document indicated ULP-F stated she did not have a second staff in the room to assist with the transfer and that she did not know how to use the Point of Care (POC, electronic record system) iPhone to review clients' service plans. The document indicated ULP-F did not review C2's paper service plan that indicated C2 required two-staff assist for transfers before she provided care. The document also indicated during review of ULP-F's personnel file the licensee identified ULP-F did not receive the supplemental agency staff training provided by the licensee prior to working with clients. This training included POC iPhone use. A review of the licensee provided document titled Supplemental Staffing Agency Orientation Checklist indicated ULP-F's date of first assignment was September 8, 2020. The same document indicated ULP-F completed the	01180		

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01180	Continued From page 11 orientation on September 28, 2020. During an interview on January 28, 2021, at 9:18 a.m., registered nurse (RN-D), who identified as the district director of clinical services stated C2 fell on September 26, 2020, and sustained injury. RN-D stated C2's care plan indicated a two-staff assist for transfers. RN-D stated she conducted an internal investigation and discovered ULP-F did not have a second staff present to assist with C2's transfer. RN-D stated ULP-F was a contracted agency staff. She stated the licensee's process with training contracted agency staff included an orientation on each client and the services required and used the Supplemental Staffing Agency Orientation Checklist. RN-D stated she discovered ULP-F did not receive the orientation. Once discovered, RN-D stated ULP-F received the training on September 28, 2020. RN-D stated ULP-F had a shadow day, the first day of her assignment. She stated ULP-F was aware of clients printed service plans and where to locate them. RN-D stated it is an expectation that contract agency staff receive orientation before providing care. During an interview on January 28, 2021, RN-E stated on September 26, 2020, the ULP provided a one-staff assist for C2's transfer and the service plan indicated a two-staff assist. She stated C2 fell, hit her head and her right eye was swollen and black and blue. She also stated C2 sustained a skin tear above her right eyebrow, scratches to the right side of her face, and C2 could not open her right eye. She stated C2 transferred to the emergency room and diagnosed with a facial contusion, closed head injury, and her facial CT scans showed a small-depressed fracture. RN-E stated after the fall on September 26, 2020, she provided education to all staff about following	01180		

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01180	Continued From page 12 clients care plans. The licensee-provided policy titled "Team Member Orientation and Training," dated December 13, 2018, indicated team members must complete orientation to the community prior to providing services at the community. TIME PERIOD FOR CORRECTION: Seven (7) days	01180		